AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 8th June, 2007, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone **01622 694486**

Tea/Coffee will be available from 9:45 am

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item		Timings
1.	Membership change- Mr J A Davies for Mr C Hibberd and Mrs B J Simpson for Mrs P V A Stockell	
2.	Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	
4.	Minutes - 11 May 2007 (Pages 1 - 30)	
5.	StourCare – Out of Hours Service* (Pages 31 - 46)	10.05-11.15am

Jayne Macdonald, Head of Primary Care and Community Contracts and Lynne Selman, Director of Citizen Engagement and Communications, Eastern & Coastal Kent Primary Care Trust will be in attendance for this item.

Break - 11.15am - 11.30am

6.	General Pharmaceutical Services (Pages 47 - 66)	11.30-12.30pm

Mike Keen of the Local Pharmaceutical Committee, Julia Ross, Director of Public Engagement, West Kent Primary Care Trust and Jayne Macdonald Head of Primary Care and Community Contracts, Eastern & Coastal Kent Primary Care Trust will be in attendance for this item

BREAK 12.30pm - 1.30pm

7. Infection Control** (Pages 67 - 134) 1.30-3.00pm

James Nash, Director of Infection Prevention and Control, East Kent Hospitals NHS Trust, Mark Devlin, Chief Executive and Iris Smith, Director of Infection Control, Dartford & Gravesham NHS Trust and Helen Goodwin, Head of Governance and Risk with Kath Hughes, Modern Matron for Infection Control, Medway NHS Trust will be in attendance for this item.

BREAK - 3.00pm - 3.15pm

8. Public Health Strategy for Kent (Pages 135 - 234) 3.15-3.45pm

Meradin Peachey, Director of Public Health and Mark Lemon, Policy Manager, Department of Public Health will be in attendance for this item.

9. Date of next programmed meeting – Friday 20 July 2007

The meeting will commence at 10.00am but the venue has yet to be confirmed

10. Fit for the Future update (Pages 235 - 236) 3.45-4.00pm

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

Stuart Ballard
Head of Democratic Services
Ext: 4002

31 May 2007

* Peter Robinson and Janet Bentley, PPIF, were also in attendance for this item (were not confirmed until after papers went out).

** Rose Gibb and Amy Page, Chief Nurse from MTW were also in attendance for this item as well (were not confirmed until after papers went out).

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KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held in the Darent Room at Sessions House, County Hall, Maidstone on Friday 11 May 2007.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr A D Crowther, Ms A Harrison, Mr C Hibberd, Mr D A Hirst, Mr G A Horne, MBE, Mr R A Marsh (substituting for Mrs E M Tweed), Mr M Northey (substituting for Mr J Curwood), Mrs E D Rowbotham, Mrs P A V Stockell, Mr R Tolputt, Mr M Vye (substituting for Mr D S Daley).

OTHER MEMBERS PRESENT: Mr G Gibbens, Mr R Parry, Mrs E M Tweed.

OBSERVERS: Mr P Gilroy, Chief Executive, Mr R Pullen, Department for Communities and Local Government, Mr E George, Legislature of St Helena, Ms E Eggington, Foreign and Commonwealth Office, Ms J Knight, Assistant Director of Citizen Engagement and Communication, Eastern & Coastal Kent PCT, Mr F Sims, Mr P G Bentley, Mr P W Skinner, Mr J Webb, Maidstone & Tunbridge Wells NHS Trust, Ms A Cole, Kent Messenger, Mrs C Swann, Mr J Reece, Patient and Public Involvement Fora representatives, Mr J A Ogden, Chairman, KCC Standards Committee, Ms E Burns, Corporate Communications, Cllr M Warner, Cllr P Germain and Ms K Harwood, Maidstone Borough Council, Dr C Thom and Dr R Hart, Maidstone BMA.

IN ATTENDANCE: Mr P D Wickenden, Overview and Scrutiny Manager, and Dr D Turner, Research Officer to the NHS Overview & Scrutiny.

UNRESTRICTED ITEMS

23. Minutes

RESOLVED that, subject to the following amendments:-

a) "Mrs F Witherdew" to read "Mrs F Witherden"; and

b) Mr Julian Brazier, MP to be shown present as an observer;

the Minutes of the meeting held on 23 March 2007 were correctly recorded and that they be signed by the Chairman.

Other Matters raised relating to the Minutes

(1) The Overview and Scrutiny Manager responded to Mr Crowther that he had been recorded as attending the visit to the Kent & Canterbury Hospital in the afternoon but as he had not attended the formal meeting of the Committee in the morning he had not been recorded in the Minutes as being present.

(2) In response to a question from Mr Hibberd about the appropriateness of recording Mr Shortt's comments in the body of the Minutes, the Overview and Scrutiny Manager explained that the Committee had been responding to a range of issues raised by Mr Shortt on behalf of Concern for Health in East Kent (CHEK).

(3) Ms Gibb, Chief Executive of the Maidstone and Tunbridge Wells NHS Trust, clarified, in respect of Minute 17 (4), that there were oncologists working across the whole of Kent and Medway; and that the point being made in her comments recorded at Minute 17 (6) was regarding the importance of having the right staff working with the right linear accelerator.

24. Maidstone & Tunbridge Wells NHS Trust – a new direction for orthopaedic and emergency care

(Ms R Gibb, Chief Executive, Maidstone & Tunbridge Wells NHS Trust and Mr S Phoenix, Chief Executive of West Kent PCT were in attendance for this item)

(1) Mr Phoenix and Ms Gibb were accompanied by some consultants from Maidstone & Tunbridge Wells NHS Trust, Mr J Webb, Clinical Director – Emergency Services and Critical Care, Mr P Skinner, Clinical Director – Orthopaedics and Mr P Bentley, Clinical Director – Surgery.

(2) Mr Angell raised a number of questions with Ms Gibb relating to:-

a) whether the calculations regarding the proposed reconfiguration took into account fully the growth in population, the ageing of the population and the growing number of overweight people;

b) what guarantee could be given as to whether the proposed reconfiguration would actually happen; and

c) whether she could guarantee that there would continue to be a quality Accident & Emergency (A&E) department at Maidstone.

(3) Ms Gibb responded that the Maidstone & Tunbridge Wells NHS Trust had given due consideration to all the demographic factors. She said that the anticipated population growth was sufficient to affect primary care but not great enough to affect planning for hospital services.

(4) She said that the changes could be concluded by December 2007/January 2008 if the NHS Overview and Scrutiny Committee agreed them. The Trust had the necessary finances and project infrastructure ready. It was imperative that the core of services must be sustainable and appropriate, otherwise the Trust would be unable to guarantee the quality and range of services. Finally, Ms Gibb concluded in response to Mr Angell's questions that they did not know how health policy and technology would change in the future but what was clear was that we could anticipate continual change.

(5) Mr Skinner, Clinical Director – Orthopaedics, added that all orthopaedic surgeons believed in the separation of elective and emergency orthopaedic care and a concentration of elective surgery at one location.

(6) It was important that there was a dedicated surgical team who could operate on emergency cases without distractions. Mr Webb, Clinical Director – Emergency Services and Critical Care, informed the Committee of an A&E middle-grade vacancy where recently there had been just one suitable applicant.

(7) He said that the Trust were very supportive, both practically and financially. Mr Webb informed the Committee that he had two Specialist Registrars based solely at Maidstone and four middle-grade staff at Maidstone and Tunbridge Wells. The nurse-provider service had been expanded at both locations. F1 and F2 staff (i.e. Housemen) were on duty overnight in A&E. He said that a 24-hour middle-grade rota at the Kent & Sussex Hospital, Tunbridge Wells would be a significant advancement. He said that the model being proposed of an integrated physician/general practitioner/nurse practitioner team with junior doctor support at Maidstone would also be a step forward. Mr Phoenix referred the Committee to the West Kent Primary Care Trust Board decision of 15 March 2007, which had attached conditions to the proposed reconfiguration. Significant checks and balances had been put in place to ensure the maximum confidence of clinicians.

(8) The Chairman then referred to the ongoing negotiations that had taken place between the spokesmen of the NHS Overview and Scrutiny Committee and the Chief Executives of both Maidstone & Tunbridge Wells NHS Trust and West Kent Primary Care Trust, and members of the Maidstone Division of the British Medical Association (BMA). Mr Phoenix referred to the most recent letter from the Committee spokesmen and said that a reply was in the post.

(9) As regards the spokesmen's stipulation that there should be an independent chairman for the external review panel that had been referred to in the conditions agreed by the PCT Board, Mr Phoenix said that he was happy to see one of the three independent members of the panel as the chairman. Regarding the involvement of the BMA in the panel, Mr Phoenix said they were a trade union and, therefore, including them on the panel would stop it being external and impartial, as they were an internal stakeholder. However, Mr Phoenix added that he was happy to actively involve the Honorary Secretary of the BMA in the process, while keeping the BMA's views external to the process. Regarding the NHS Overview and Scrutiny Committee reserving the right to re-open the issue, he said that this was a constitutional matter which would need to be considered. Regarding the request for clarification as to why the Trust intended that Maidstone A&E department would be staffed by A&E specialists for 15 hours per day, rather than 16 hours or more, Mr Phoenix said that 15 hours per day was the existing extent of cover. Mr Phoenix then referred to the Committee spokesmen's request to see the document detailing the changes to Ambulance Service resources that would be necessary if the proposed reconfiguration were to go ahead. Mr Phoenix said that it had been agreed to make this document available to the Committee.

(10) Responding to a further question about the chairing of the external review panel, Mr Phoenix confirmed he had accepted that an external clinician would chair the

panel. A question was asked as to whether there would continue to be a 24-hour A&E service in Maidstone. A further question was asked about the distance between Maidstone and Tunbridge Wells with reference to what was commonly known as “the magic hour”, referring to the time during which it was critical that an emergency patient receive treatment. Mr Webb said that the doors of the A&E department at Maidstone would be open 24 hours a day. He added that what used to be done in hospital within “the golden hour” was now being done by ambulance crews.

(11) He went on to refer to some of the major specialties, such as brain, burns and cardiothoracic services that had already been centralised. This meant that Maidstone Hospital already routinely transferred all sorts of emergencies. As a specific example, he referred to the instance of a leaking aneurysm. In the past, this would have been dealt with by a general surgeon at a district general hospital. Now, however, it was undertaken by a specialist vascular surgeon. Increasing specialisation was the direction in which medicine in general was headed.

(12) Mrs Stockell returned to the issue of staffing of A&E and how it was dependent on the external review agreed by the PCT Board. She asked whether the NHS Overview and Scrutiny Committee would get the opportunity to come back to the matter when the outcome of that external review was known.

(13) She also asked about the growth of population, which the Trust was acknowledging it had failed to take full account of. Mrs Stockell further asked whether A&E at Tunbridge Wells would also be open 24 hours a day.

(14) Mr Phoenix responded that A&E at Tunbridge Wells would be a 24-hour service. In response to an interjection by Mrs Stockell, Mr Phoenix confirmed that trauma services would be concentrated at Tunbridge Wells. Responding to the point raised about population growth, Mr Phoenix said that Maidstone would be experiencing an increase of 10,000 in the number of households over the next ten years.

(15) He said that 500,000 was now considered the optimal catchment population for acute services. A 10,000 to 20,000 increase in the population would not require a material alteration in the shape of the service. An increase in patient volume on that scale could be accommodated without configuring acute services differently.

(16) He went on to add that work on projected population changes had already been undertaken in planning for the Private Finance Initiative (PFI) at Pembury. He said that population forecasting was not an exact science. The PCT was planning to invest more in primary and community care to take account of population changes.

(17) In response to Mrs Stockell’s point about revisiting the issue once the external review panel had completed its task, Mr Phoenix said that, in his view, the Committee was not best placed to review operational staffing matters. He added that it was for the PCT to performance-manage the outcomes of the external review panel, but he would be happy to report the outcomes back to the NHS Overview and Scrutiny Committee.

(18) Mr Fittock said that he did not want to revisit all the issues which the spokesmen of the Committee had addressed with Mr Phoenix and Ms Gibb already through the negotiations. Appendix 2 to the report before the Committee represented the spokesmen's understanding of the current position with regard to these negotiations. However, he went on to say that he would welcome the NHS Overview and Scrutiny Committee Chairman, Mr Chell, being an observer on the external review panel. Mr Fittock said the Committee spokesmen had "moved the goalposts" somewhat by stipulating that specialist cover must be present at Maidstone A&E department for a minimum of 17 hours per day.

(19) With regard to the spokesmen's concerns around Fit for the Future, he felt that the Trust and the PCT had covered this. This left the questions relating to the Ambulance Service and he understood that the Ambulance Service had responded.

(20) The Overview and Scrutiny Manager then read to the Committee a message from Geraint Davies, of the South East Coast Ambulance Trust, a copy of which is attached as Appendix 1 to these minutes.

(21) Mr Phoenix responded that he did not have a problem with Appendix 2 to the report. He said that this was an accurate reflection of the negotiations which had taken place between the spokesmen of the NHS Overview and Scrutiny Committee and the Trust and PCT.

(22) He added that he had no problem with a representative of the NHS Overview and Scrutiny Committee observing the external review panel. Ms Gibb said that the comments on Appendix 2 to the NHS Overview and Scrutiny Committee's report were from the Committee's perspective. She added that the assurances that the spokesmen had sought on behalf of the Committee had been given by the Trust and PCT.

(23) In response to Mr Fittock's question about specialist cover in Maidstone A&E, she said that 15 hours would actually represent an increase on the current situation. She added that the external review panel would not itself determine the levels of staffing but that it would determine whether the proposals about this put forward by the Trust were appropriate and safe.

(24) Mr Vye said that he understood the arguments being made about getting patients to specialists who were equipped to provide the best outcome. However, he added that time-to-surgery was still an important consideration. He sought confirmation that there would still be the capacity to deal with some emergency surgery cases at Maidstone Hospital, where necessary; and also that it would be possible to stabilise patients before transferring them, where necessary. He asked how these situations would be handled during those parts of the day when relevant specialist cover was not being provided, given that such cover was not going to be available on a 24-hour-a-day basis. Ms Gibb responded that they did not at the current time have a proper 24-hour service – people often had to wait for a specialist. She listed again the specialist services that the Trust did not provide, such as dealing with head injuries. She added that if a patient needed immediate surgery and no

surgeon was on site, then the patient would be stabilised while a surgeon was sought and a theatre opened.

(25) Mr Bentley, Clinical Director – Surgery, informed the Committee that Maidstone would have the best specialist major surgery centre in the area. He said that two new specialist consultants had recently been appointed who were "utterly brilliant" and patients would flood in. He added that the on-call surgeons at Maidstone would not be the same surgeons who were on-call at the Kent & Sussex Hospital, Tunbridge Wells. If necessary, surgeons would be called in to Maidstone and patients would be stabilised and then treated; but often it was actually dangerous to treat patients straightaway. He said that stabilisation of a patient could take four, six and sometimes 10 hours. He reassured the Committee that patients at Maidstone would be properly covered. Mr Horne said that the proposals before the Committee had turned out to be very contentious. Mr Phoenix had said that the Committee was not well placed to know about operational matters. However, Mr Horne said, the Committee was well placed to represent the views of the public – and they were very worried. He said that the Trust's role was to reassure the public that the proposed service changes were in their best interests.

(26) If the service to be provided at the Maidstone Hospital A&E department was only for 15 hours then people would feel that the service was being reduced. Mr Horne also expressed concern that these proposals had been put forward before the Fit for the Future consultation process had been concluded. He said that he needed to be convinced that the Trust and PCT were looking at improving services not reducing them. He said that the medical profession had also voiced doubts and concerns. Ms Gibb responded that change was never easy and was always painful. To demonstrate the point, she referred to the consultation some years ago on the provision of vascular services across Kent and Medway when there had been a huge outcry at what people had seen as a loss of services. People had said that the service would fall apart and that, as a result, patients would die. However, the reality was that this had not happened; the outcome had been better services, and patients had been convinced. Hearts and minds would change, she said, when people saw the service in operation. Ms Gibb said that she was still hearing confusion from Members present at the meeting. For example, she said, specialist staff were not available now 24 hours a day – or even 15 hours a day. Changes could be seen as a reduction in services, but if you saw the right specialist at the right time, the outcome was better; and UK and international evidence showed that. Mr Phoenix added that, having spent nearly 30 years in the National Health Service, he saw many buildings that were still the same, but what went on in them had changed beyond recognition. He said that during the last five to 10 years the pace and scope of change had been much greater than before. He emphasised that clinical testimony was very important. He referred the Committee to the fact that the PCT had had signed letters from all the surgeons in the Trust supporting these proposals. Mr Hirst said that change was very difficult and that the Committee was caught between the electorate and reality. He said that the electorate was living in the past, with a lack of comprehension of the consequences of not changing. He said that County Councillors were "going with the flow" and following the electorate. He said that they had been through all of this in Canterbury and they now had a service there that was far better than they had had before. Was the Committee going to go through this with every Trust? What

would it do to the NHS if elected Members blocked every necessary change? Ms Gibb responded that it was not possible to ignore the factors that were driving change and that similar changes were taking place up and down the country. If the Committee were to support the changes there would be a sound service.

(27) Ms Gibb referred to the work of Professor Sir Ara Darzi, which showed that some services would have to change even more. A "critical mass" catchment population of 500,000 people was vital to delivering good-quality health outcomes. Across England, and Scotland too, there was the same process of change, leading to centralisation. Mr Hibberd said that he was surprised by the amount of public protest by the medical profession. He had been informed that the BMA still had reservations. He asked the Trust and PCT representatives whether they were satisfied that medical staff were behind them. Ms Gibb said that it was not always possible to get 100% staff support – but 100% of the surgeons were in favour. Some concerns were being expressed by physicians, which had also been the case in respect of the changes in Canterbury. She said it was not unique for clinicians to oppose proposals; this had also occurred in Maidstone & Tunbridge Wells NHS Trust in 1999 and when the vascular review had been undertaken. It was actually rare to get what had been achieved in the present case, namely 100% agreement from the surgeons.

(28) Ms Harrison said that at the last meeting of the Committee there had been a lot of myths; for instance, some people had believed that the hospital was closing. She had thought that the Committee had nailed those myths. There was a need to spell out in words of one syllable what was proposed. The Committee could have done a lot to help public understanding. Trust staff were saying that fewer people would die as a result of the changes. Unless the Trust was telling the Committee a pack of lies, the proposals would actually improve services. Yet the newspapers were reporting that the hospital was closing. Ms Harrison found similar misleading perceptions about NHS services in the area that she represented.

(29) Ms Gibb responded that they had had a clear and consistent message to give and she did not know how it could have been said in simpler terms. The confusion perhaps arose in these matters when people started negotiating.

(30) Mrs Rowbotham spoke about provision for the repatriation of patients to Maidstone if the proposals were implemented. The general public were concerned about bus services not running in the evenings. Would people find themselves stranded? Mr Phoenix responded that the Trust already dealt with travel difficulties now according to people's circumstances. He said that south west Kent had a level of car ownership that was amongst the highest in the county. He also informed the Committee that the changes being proposed would not be affected by car-parking charges.

(31) Mrs Loveday, Chairman of the Patient and Public Involvement Forum for the Maidstone & Tunbridge Wells NHS Trust, said that a Trust representative had attended one of their meetings to explain the proposed change. She felt that there were considerable benefits in the proposals being put forward by the Trust as regards dealing with the issues of cross-infection and mixed-sex wards. She said she felt people that were currently opposing the change would come round to supporting it when it was in place.

(32) Mr Germain, Chairman of Maidstone Borough Council's external scrutiny panel, was then invited to comment. He said that he would not deal with the technical matters as he did not fully understand them – and he suspected that most people present did not either. He said that he agreed with Mr Horne that the Trust had not convinced people that their county-town hospital was not being downgraded. He said that, when consulted, the people of Maidstone rejected the proposals; so he questioned what the point of consultation actually was. Mr Phoenix made it clear to the Committee that it was the PCT that had responsibility for the consultation process and not the Trust. He said that they had had to put in place a comprehensive process of consultation, which they had done; he was sure that, with the benefit of hindsight, they could they have done things better. He said that it had been West Kent PCT Board's responsibility then to take a decision, in the light of responses received, in the best interest of patients. A lot of the comments that had been received had been predicated on wrong assumptions. The decision had had to be made on the quality, rather than the weight, of opinion expressed.

(33) The PCT Board believed that the proposals would be more convenient and safer than current arrangements, reducing cross-infection and mortality. Twenty-four-hour A&E cover at the Kent & Sussex Hospital, Tunbridge Wells would be an improvement on the current situation. Mr Phoenix acknowledged that a lot of people were frightened and misunderstood the proposals. He acknowledged that the easiest thing that the Trust could have done would have been to take the path of least resistance; but he could not in all conscience have done so.

(34) Dr Thom, representing the Maidstone Division of the BMA, then addressed the Committee. He said that the NHS Overview and Scrutiny Committee had played an enormously helpful role in counterbalancing the corporate management view. The issue was to balance the need for centralisation against the need for local services. This was a national issue.

(35) From the BMA's perspective, the missing ingredient in the proposals had been a clear idea of what was needed for a viable emergency hospital. There had now been considerable improvement in the way the proposals were elaborated. However, Dr Thom pointed out that there remained some areas of concern:-

a) medical staffing in A&E – if staffing levels were maintained, then rotas could be sorted out to allow A&E to be staffed adequately;

b) general medical training;

c) provision for surgical assessments to be carried out at Maidstone when necessary.

(36) Dr Roger Hart, Honorary Secretary of the Maidstone Division of the BMA, said that he was very impressed with the conditions that the PCT Board had imposed on the Trust's proposals. These conditions had taken into account a lot of the questions raised by Maidstone BMA. However, what was missing was the detail. He insisted that the planned external review must be genuinely external and he made a suggestion that it should be for the College of Emergency Medicine to appoint the

chairman of the review panel. Dr Hart wished to state that 44% of BMA members in Maidstone had voted in their ballot on the reconfiguration, although the Trust and PCT had tried to dismiss this vote as unrepresentative. He also wished to state that Maidstone A&E was clearly being downgraded from a Level II Trauma Centre to a Level III centre. This was indicated by the fact that the helipad at Maidstone Hospital would no longer be used. Mr Phoenix replied that the PCT seemed to have been "damned with faint praise" for actually moving the matter on. The BMA did appear to be saying that the conditions agreed by the PCT Board had in fact addressed their concerns. As regards the helipad, he said that the use of the Air Ambulance was actually a rare event; and the helipad at Maidstone would still be used for transfers of patients. There were informal arrangements to land the Air Ambulance at the back of the Kent & Sussex Hospital, Tunbridge Wells, although he accepted that this was not the same as having a helipad. He reaffirmed that the external review panel must be genuinely external. Ms Gibb said that there had been dialogue, which was what consultation was about. The Trust had listened, and modified and changed its position during the consultation. There were still concerns about the details, but the Trust needed to have a decision so they could move on and deal with those details.

(37) Mr Marsh informed the Committee that he was a substitute at the meeting but he had had 22 hours to study the papers. He said that the issue was not about politics but about people. He said it was not about getting a message across but about care. He said it was condescending to say that people did not understand. The Trust and PCT ignored the people of Kent at their peril. He felt it was also condescending to say that the Committee could not understand the details. Members could certainly represent the people of Kent. For the Committee to respond after the external review, he thought, would be "shutting the stable door after the horse had bolted".

(38) Mrs Tweed talked about the underestimation of the projected population growth in Maidstone and the additional pressure that that could place on A&E services at the William Harvey Hospital, Ashford.

(39) Mrs Stockell said it was wrong to say that people did not understand the issue. The BMA were experts and they were opposed too. She also asked about journey-to-hospital times, and accused the Trust and PCT of using "woolly and weasely" words that were not very convincing. She stated that Maidstone Hospital was being downgraded and that was a fact. Mr Phoenix responded that his comments about Members not understanding had actually been a response to comments that Members themselves had made about their difficulty in understanding technical matters. He said that Mr Marsh had twisted some of his words and he would leave it at that. Ms Gibb added that she recognised that people had a passion for bricks and mortar. Mrs Stockell responded to that comment by saying the issue was not about bricks and mortar but about services. Ms Gibb replied that the Trust had invested heavily in Maidstone Hospital. Downgrading of Maidstone Hospital had been talked about on several occasions and she once again referred to the review of vascular services, which had not led to a downgrading of the service but rather the creation of a centre of excellence. Comments in the press to the effect that A&E was closing or that Maidstone Hospital was closing were not accurate or true. That was, however, what people had written in and protested about. Mrs Stockell

asked again about travel-to-hospital journey times. Ms Gibb answered that the Ambulance Service did not think there was a problem. Blue-light ambulances could get through quickly – and certainly more quickly than a car could. She pointed out that a lot of people would need to travel from Tunbridge Wells to Maidstone for elective surgery in future under the proposals, so the change would not be all in one direction.

(40) The Chairman, Mr Chell, informed the Committee that a lot of progress had been made. In his view, the proposals now before the Committee, having been amended through negotiation with the Trust and PCT, were now close to being acceptable – subject to clarification of some minor details and to the conditions that had been imposed on the Trust by the PCT Board. He moved that, on this basis, the proposed reconfiguration proposals be accepted, subject to clarification of minor details and the outcome of the external review. This was seconded by Mr Fittock. The matter was put to the vote, with five votes for the motion, eight votes against and two abstentions.

(41) Mr Fittock then asked that the Overview and Scrutiny Manager record the way that Members had voted.

For:- Mr M J Fittock, Mrs C Angell, Ms A Harrison, Mrs E D Rowbotham, Mr M J Vye.

Against:- Mr M J Angell, Mr A D Crowther, Mr C Hibberd, Mr G A Horne, Mr R A Marsh, Mr M Northey, Mrs P A V Stockell, Mr R Tolputt.

Abstain:- Mr A R Chell, Mr D A Hirst.

(42) Mr Fittock then said that he felt it was unconstitutional not to have debated the motion before voting. Mr Wild advised the Committee that, a vote having been taken, the item of business was now closed and the Committee should move on. Mrs Stockell moved, seconded by Mr Northey, that, the negotiations having been exhausted without a satisfactory outcome, the proposed reconfiguration and the decision of the West Kent Primary Care Trust Board should, therefore, be referred to the Secretary of State for decision. In debating the motion, Mr Fittock said that the Committee spokesmen had set out for the Trust and PCT a number of reasons for opposing the reconfiguration. The Committee's three spokesmen had worked hard to pursue these objections and other issues, which had all been dealt with satisfactorily. Mr Northey said that he did not like the separation of clinical and human factors, as regards it being more difficult for patients to receive visitors by virtue of being in hospital further away from home. Patient visits were part of the healing process. It was not true that people did not understand. People knew when something was being taken from them. He said that Maidstone was the county town of a major county of England. He referred to the reconfiguration of services in Canterbury, which he said had left the local population with a feeling that they had no longer got what they once had. Mr Hirst asked why the Kent & Canterbury Hospital had ended up with such a huge deficit. He said it all went back to what was being talked about here. There had been a protracted fight, but no extra money had been forthcoming from the Secretary of State. In this instance too, the Secretary of State would not bail them out. All that was happening was that the

inevitable was being delayed. There was only so much money, and everything had to be balanced. He felt it was not appropriate to transfer the responsibilities of the NHS Overview and Scrutiny Committee to central government and that matters should be resolved locally. Mr Vye said that referral would delay bringing into being services that would save lives. The Committee needed to move on. There was not a huge number of the highest qualified surgeons in the country. The service was not sustainable on two sites. He said that the issue of Maidstone's county-town status was not relevant and the issue of visitors for patients was a separate matter. Ms Harrison said that Members had clearly not read the papers before them and they were just being political. Members did not want to take a decision that would be unpopular. She said that the proposals were about "need" not "want". Her constituents wanted 24-hour A&E facilities, but the clinical need was not there. The Committee was being told that this was an improvement of services. Members had made their minds up two-and-a-half hours ago – if not months ago. If Members of the majority party wanted to make the Committee political, then Opposition Members would do the same. She said that the proposals were in the best interests of Maidstone, Tunbridge Wells and Kent – but not, it seemed, the Conservative Party.

(43) Mr Hibberd said that the Committee had not reached an agreement, so referral was the best way to get out of this tangle. Mrs Stockell said that she was sorry about Ms Harrison's comments; Ms Harrison did not represent people in Maidstone as she (Mrs Stockell) did. What was before the Committee was better than before, but it was still full of "maybes". She said the experts had said that the hospital was being downgraded from Level II to Level III. There had been some improvement in the proposals, but they were being told to "take it or leave it", which she found to be antagonistic. Mr Angell said that the Committee had reached a defining moment in its life. Referral to the Secretary of State was a last resort. The Committee had had good relations with the Trust and PCT, and meetings had always been cordial and cooperative. However, the reasons given for the changes were weak. Mrs Angell said that saving lives was not a "fundamentally flawed" reason for change. She referred to one of the other items on the agenda, where reference was made to the protocols for the operation of overview and scrutiny of the NHS across Kent; there was talk about approaching things on a partnership basis and working with NHS bodies, not against them. The attitude of some Members on this issue was not in that spirit. Mrs Rowbotham said that the issue was to achieve proper care in the proper place. She wondered if opening hours could be extended during school holidays. As regards the high level of car ownership, which had been referred to, she was concerned about the environmental impact of any policy that caused people to use their cars more.

(44) The Chairman then put to the vote the motion proposed by Mrs Stockell, and seconded by Mr Northey, that the proposed reconfiguration and the decision of the West Kent Primary Care Trust Board be referred to the Secretary of State. The vote was taken and the result was eight votes for, five against and two abstentions. Mr Fittock then asked that the way Members had voted be recorded.

For:- Mr M J Angell, Mr A D Crowther, Mr C Hibberd, Mr G A Horne, Mr R A Marsh, Mr M Northey, Mrs P A V Stockell, Mr R Tolputt.

Against:- Mr M J Fittock, Mrs C Angell, Ms A Harrison, Mrs E D Rowbotham, Mr M J Vye.

Abstain:- Mr A R Chell, Mr D A Hirst.

RESOLVED:-

that the proposed reconfiguration and the decision of the West Kent Primary Care Trust Board be referred to the Secretary of State.

25. Business Plan for the Private Finance Initiative (PFI) – Pembury
(Ms R Gibb, Chief Executive, Bernard Place, Commissioning and Healthcare Director and Laurence Bunnett, PFI Director, Maidstone & Tunbridge Wells NHS Trust and Mr S Phoenix, Chief Executive of West Kent PCT were in attendance for this item)

(1) The Committee received a presentation on the Business Plan for the Private Finance Initiative (PFI) at Pembury, which is attached as Appendix 2 to these Minutes.

(2) Mr Horne said that the new Pembury Hospital was required as quickly as possible. He had specific questions around the renal unit, the diabetes unit, rehabilitation and continuing life care for people with long-term conditions. He also mentioned concerns relating to the A21 in respect of dualling the carriageway, which he saw as a big issue for the PFI project. Mr Phoenix said that the West Kent PCT was discussing with Guys and St. Thomas' NHS Foundation Trust in London the positioning of the renal unit in a new location, which need not be at an acute hospital site. He referred to the West Kent PCT Board report that was being prepared for the Board's meeting on 24 May 2007, relating to the Community Hospitals review, which would mention the renal unit.

(3) Mr Phoenix also said that diabetes services did not have to be at an acute hospital site either. Mr Place said that some intense short-stay rehabilitation would be at the new hospital but the rest did not necessarily have to be provided at the hospital. Mr Bunnett said that upgrading the A21 was not a critical precondition of the hospital getting built, but there could be a helpful congruence of these two issues. He said that issues around the A228 would also not be an obstacle to the project going ahead. The Trust were working on the question of traffic profile.

(4) Mr Phoenix said, in response to the question about long-term care, that this would not be provided in acute hospitals. Once again, he referred the Committee to the proposals on Community Hospitals – although these were not necessarily the best place either for people who needed care but not medical care; they were better looked after at home or in "more homely settings".

(5) Members asked a series of questions about the source of funding for the PFI; whether the building would be environmentally sustainable; and ensuring that car-parking would not be a "cash cow". Ms Gibb responded that the construction project would not be publicly funded but, as a PFI project, would use wholly private finance. Sustainability and environmental issues would be looked at. The government's review of the project had stated that health issues needed to be reflected in the plan. Local labour would be used where relevant and appropriate, but the project would be in competition for local labour with the 2012 Olympics. Ms Gibb confirmed that cancer patients who had to attend the hospital on a regular basis for treatment would receive a car-parking pass. In answer to a question around the funding of the PFI and whether Value Added Tax would be payable, Mr Bunnett confirmed that VAT was not applicable in the case of a PFI project. If the hospital were to be built under traditional public-sector procurement arrangements, then VAT would be payable.

(6) Mr Vye asked some questions around mental-health provision and said that co-location of these services at the acute hospital site would be a good idea. Mr Phoenix confirmed that the PCT was looking into this with mental-health colleagues as regards bed availability. However, he said it was unlikely that the PFI project would include a dedicated mental-health unit. Mr Phoenix informed the Committee that in West Kent there was a lack of mental-health beds in a community setting. He said that also they were not making the best use of what beds they already had. Therefore, it was not appropriate to be including a mental-health building in the plans for the new PFI project. The Trust representatives responded to questions relating to the provision of individual rooms for all patients within the PFI project. Regarding how the hospital was to be paid for, Mr Phoenix confirmed that this would be through annual payments by the Trust to the PFI company from funds supplied by commissioning PCTs for services provided (which was, of course, taxpayers' money).

(7) The Committee noted that the travel plan would address the road issues. Mr Horne returned to the dualling of the A21 and improvements required for the A228. He said that the A21 was a trunk road and so not a County Council responsibility. However, the matter should still be raised with KCC's Highways department. He said it was important that both patients and doctors had decent road connections. The Committee noted that work on the PFI project would start early in 2008.

26. Fit for the Future update

(Mr S Phoenix, Chief Executive of West Kent PCT was in attendance for this item)

(1) Mr Phoenix informed the Committee that the PCTs in Kent were working towards a consultation document being available by July for the whole of Kent and Medway. This would incorporate the feedback and responses from local "co-design" meetings. The consultation document would deal with forecasting the future financial position across Kent and Medway up to 2015–6. Fit for the Future had been initially predicated on the assumption that there would be a severe financial crisis if nothing happened, but this was no longer the case. The emphasis would now be on the need for more care to be provided in the community. This was about the type, levels and settings of care in the community. He said that it would not be possible to have a once-and-for-all consultation, as things were changing all the time. For instance, he expected very soon to have revised guidelines on stroke-handling. The new standards would require every hospital to do things differently. There would be a network model and not every hospital would do everything. Fit for the Future was unlikely to propose major infrastructure changes. Mr Phoenix offered to come to the July meeting of the NHS Overview and Scrutiny Committee for a preliminary conversation about Fit for the Future.

(2) The Chairman asked whether there would be a common approach to Fit for the Future across the whole of Kent and Medway. Mr Phoenix responded that there would be a single document, localised to particular areas. Mr Horne referred to a 16,000-signature petition relating to the Tonbridge Community Hospital, as well as to similar campaigning in other areas. He asked Mr Phoenix whether Fit for the Future would cover the future of the Community Hospitals. Regarding the renal unit, he asked how this would be paid for. Mr Phoenix responded that Fit for the

Future would reflect proposals on the future of the Community Hospitals that would be in a separate report, which was going before the West Kent PCT Board on 24 May 2007. He said that it would have something exciting and positive to say. With respect to the renal unit, he said that the PCT was already paying Guy's and St. Thomas' Trust, as a specialist provider, for the use of this service. The question was only one of how the service was to be provided in future.

(3) Asked a question about the capital implications of providing care closer to home, Mr Phoenix said that there would be some capital implications but not many. He said that, with the new hospital at Pembury, the county would have the most up-to-date hospital stock in the country. Pembury Hospital would be very new; Darent Valley Hospital was new; Gravesham Community Hospital was new; and Maidstone Hospital was relatively new in NHS terms – and parts of it were very new.

(4) RESOLVED that:-

the position be noted.

27. NHS Overview and Scrutiny Committee – Work Programme and Update on Committee Activity

(1) The Overview and Scrutiny Manager submitted a report updating the Committee on the future work programme and a number of other issues.

(2) Asked about the establishment of a Local Involvement Network (LINk), the Overview and Scrutiny Manager said that reports would be made to the Committee in July and November on the proposal to establish a LINk.

(3) The Overview and Scrutiny Manager made reference to a visit by some Members to the Kent headquarters of the South East Coast Ambulance Service, which had been excellent. He asked if the Committee would welcome a repeat visit. He also asked whether Members would like to visit the Integrated Clinical Assessment and Treatment Service being operated as a pilot in Ashford. The Committee agreed that both these proposed visits would be useful.

(4) Mr Horne raised the issues of: the lack of NHS dentists in Tonbridge; and the future of Tonbridge Cottage Hospital. The Overview and Scrutiny Manager said that, with regard to the Community Hospitals, Fit for the Future was a standing item on the NHS Overview and Scrutiny Committee's agenda and the Committee could maintain a watching brief on this issue under that heading. He also reminded the Committee that its Members and all those who represented an electoral division in West Kent had been invited to a stakeholder meeting about the review of Community Hospitals in West Kent on the afternoon of 17 May at Tonbridge.

(5) Questions were then asked about the homeopathy review being undertaken by West Kent PCT. The Overview and Scrutiny Manager reported that the consultation document was included in the papers before the Committee for their information. The consultation finished on 2 July and a report would be submitted to

the West Kent PCT Board on 26 July. He indicated that if Members had any comments that they wished to make they should make these direct to the PCT. In response to comments from one of the Members of the Committee that there was too much business on the NHS Overview and Scrutiny Committee agendas and that some of the items before them could be tackled informally, the Overview and Scrutiny Manager referred the Committee to the protocols for the operation of NHS Overview and Scrutiny across Kent. These protocols were currently being revisited by a steering group including health, Patient and Public Involvement Forum, and Borough and District authority colleagues. Consideration would be given to delegating some of the work of the NHS Overview and Scrutiny Committee to Boroughs and Districts, which had always been the intention within the existing protocols. He referred the Committee to the issue of the proposed Whitstable Polyclinic, which had been tackled at the last meeting of the Committee, held in Canterbury on 23 March. There was a clear willingness on the part of Canterbury City Council to take forward the overview and scrutiny of this issue.

Chairman ……..

Date 8 June 2007

Appendix 1

The following points were relayed in a telephone call on 10 May 2007 by Geraint Davies, Director of Corporate Affairs & Service Development for the South East Coast Ambulance Service:

- The Ambulance Trust has been actively involved in discussions with both the hospital Trust and the PCT about the MTW reconfiguration plans.

- The additional capital and revenue resources that the Ambulance Trust requires in order to cope with reconfiguration have been clearly identified. They need one extra ambulance vehicle and crew.

- The consultants that were involved in identifying the additional resource requirements, Operational Research in Health (ORH) Ltd, are recognised as leaders in the field of identifying the ambulance-resource implications of hospital reconfigurations.

- The Ambulance Trust will be happy to share ORH's report with the NHS OSC. It's not a confidential document.

Appendix 2

Maidstone and Tunbridge Wells NHS
NHS Trust

Overview & Scrutiny Committee
11th May 2007

Update on Pembury Redevelopment

1

Trust Attendees

Rose Gibb	Chief Executive
Bernard Place	Commissioning & Healthcare Director
Laurence Bunnett	PFI Project Director

2

Acute Hospital Proposals

Strategic Context

3

Maidstone and Tunbridge Wells NHS
NHS Trust

Strategic Context – 1
Geographic location

4

Strategic Context – 2
Context

- Population
  - Resident 465,500,Wards 27, 4 local boroughs
  - Geographic range of 30 x 30 miles
- Provision of all forms of acute hospital and emergency services
- Provision and specialist services for:
  - Cardiology, complex surgery, foetal and maternal medicine
- Provision of specialist services to West Kent population for:
  - Ophthalmology, children's endocrinology and gastroenterology
- Provider of tertiary services in cancer and complex surgery for:
  - 2.3 million across the county of Kent & Medway up to & including Hastings & Eastbourne
  - Geographic range of 46 x 61 miles, and 72 wards

5

Strategic Context – 3
Trust response

- Ambulatory care and care close to patients' home
- High cost or low volume care, centralised using a hub and spoke model
- Provider of specialist and complex rehabilitation on acute hospital sites
- Day case, one-stop specialist and complex ambulatory services at both sites
- Elective & emergency patient flows, separated, ring fenced elective facilities
- Services to link smoothly between acute, primary, community and social care
- Can be the provider of non acute hospital based specialist or complex services off acute sites

6

Strategic Context – 4
Pembury Redevelopment

- Consolidates Kent and Sussex and Pembury services
- Enables consolidation of Trust obstetric and paediatric services
- Enables final bed stock efficiencies, eradicating duplicate working and rotas
- Provides modern estate and equipment replacing old building stock
- Backlog maintenance £60m eradicated

7

Maidstone and Tunbridge Wells NHS
NHS Trust

Strategic Context – 5
Trust service profile

Critical Care Centre, Tunbridge Wells	SERVICES	Local Hospital and Tertiary Centre, Maidstone
✓	Specialist OPD	✓
✓	Diagnostics	✓
✓	Medical	✓
✓	Surgery	Day case ISTC + Elective IP's
✓	Trauma & Orth	Day case ISTC
✓	Obstetrics	Midwife Unit
✓	Paediatrics	Ambulatory care
Day case	Oncology	✓
Day case	Cancer Surgery	✓
Day case	Urology	✓
Level 2 trauma	A&E	Level 3

8

Pembury Redevelopment – 1 Statistics

- Approx. 65,000 sqm
- Approx. £290m public sector (£241m ex. VAT at outturn prices)
- Beds: 512 (100% single room approach)
- Theatres: 8 major + 2 obs
- Outpatient rooms: 37
- Hard Fm by ProjCo, Soft Fm by Trust or Trust party

9

Pembury Redevelopment – 2 (PFI) Procurement Process

- Strategic Outline Case (SOC)
- Outline Business Case (OBC)
- Tender/Selection process – PITN/FITN
- DOH PFI Review
- Post FITN Process
- Provisional Preferred Bidder
- Appointment Business Case completion
- Pref'd Bidder & Planning application submission
- Completion of design & contractual negotiations
- Final Business Case (FBC) completion
- Contract sign (Financial Close) & Construction Start

10

Pembury Redevelopment – 3
PFI Review Overview

- Review implemented Nationally
- Tests and requirements:
  - Care closer to home agenda (sustainability)
  - Project deliverability (build-ability)
  - Introduced 15% metric (affordability)
  - Introduced ABC requirement

11

Pembury Redevelopment – 3
Care Model Principles - 1

- Patient Safety Design
  - Infection control
  - Falls
  - Medication errors
  - Sleep and rest
- Therapeutic Environment
  - Light
  - Ambient acoustics
  - Views
  - Colour

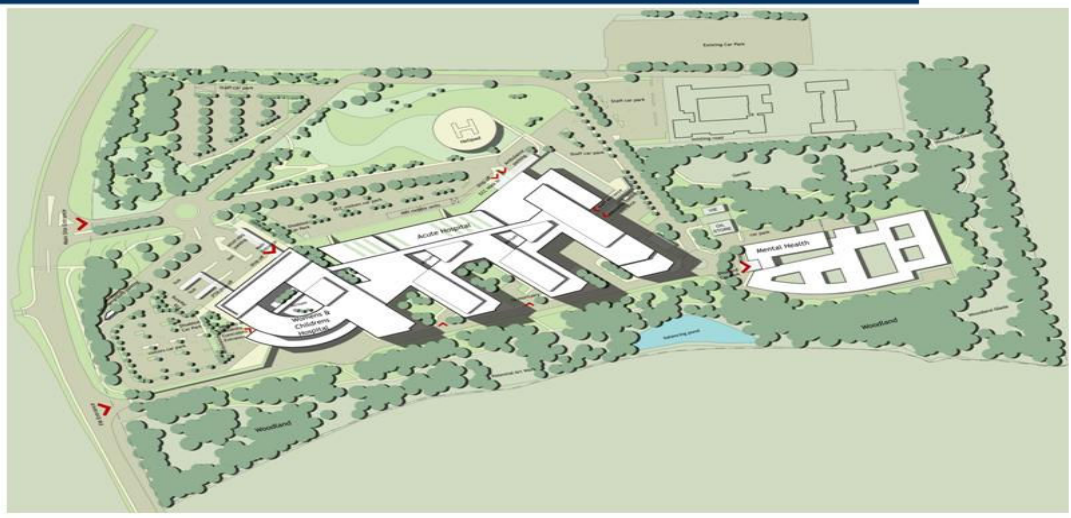
12

Pembury Redevelopment – 4
Care Model Principles - 2

- Patient and Family centred care
  - Patient preference
  - Privacy and dignity
  - Involvement of carers
- Care close to patient
  - Near patient data entry
  - Distributed nursing stations
  - Rehab by bed
  - Rehab embedded in ward
  - Minimum intra-hospital moves
- Maximised 'purposeful nursing care'
  - 30% direct care to 60% direct care
  - Walking distances
  - 'Vocera' technology

13

Pembury Redevelopment – 5
Site design



14

Pembury Redevelopment – 6 Room design proposals

Figure 2: The therapeutic environment (acute bedroom shown)

15

Traffic & Transport Issues – 1

- Car Parking
  - 1200 Spaces in outline plan
    - Acute
    - MHU
  - In dialogue with planners (full plan)
  - New Traffic Impact Assessment required
  - Travel Plan

16

Traffic & Transport Issues – 2 Highway Infrastructure

- Dialogue with Highways Agency (A21)
- New DoT (Dept of Transport) Circular
  - Transport Impact Assessment
  - Travel plan
- Trust commitment to access

17

Programme update

- ABC
  - Issued to SHA and DH
  - Approval end June/mid-July
  - Pref'd bidder appointment post sign-off
- Design development
  - Work in progress with Provisional Pref'd bidder
  - Planning application under preparation
- Contract preparation
  - Legal & commercial terms for contract nr completion
- Development works
  - Enabling works in progress (lower site clear, asbestos removal)
  - Contract sign and major work start early 2008

18

Appendix 1

The following points were relayed in a telephone call on 10 May 2007 by Geraint Davies, Director of Corporate Affairs & Service Development for the South East Coast Ambulance Service:

- The Ambulance Trust has been actively involved in discussions with both the hospital Trust and the PCT about the MTW reconfiguration plans.

- The additional capital and revenue resources that the Ambulance Trust requires in order to cope with reconfiguration have been clearly identified. They need one extra ambulance vehicle and crew.

- The consultants that were involved in identifying the additional resource requirements, Operational Research in Health (ORH) Ltd, are recognised as leaders in the field of identifying the ambulance-resource implications of hospital reconfigurations.

- The Ambulance Trust will be happy to share ORH's report with the NHS OSC. It's not a confidential document.

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SUBMISSION TO NHS OVERVIEW & SCRUTINY COMMITTEE on 8 June 2007: OUT OF HOURS SERVICE (OOHS) - STOURCARE COMMUNITY INTEREST COMPANY

1. Introduction & Summary

1.1 This issue which concerns the provision of out of hours GP services in the Canterbury and coastal areas was first drawn to your attention on 27 April 2006 having been referred by the then Canterbury and Coastal PPI Forum under Section 7.1 of SI 2003 No 2124, The Patient's Forum's (Functions) Regulations 2003.

1.2 On 23 March 2007 I attempted to bring you up to date but because of very tight time constraints I was able only to give a brief summary of the issues involved so that it was agreed to reschedule discussion for a subsequent meeting particularly as the final decision of the joint PCT, Stourcare and Forum Review Group was due that afternoon.

1.3 Before I explain in more detail the basic facts are:-

- Initially, in September 2005, the PCT announced that the Stourcare base in Herne Bay which served the whole area would close and OOHS move to KCH to co-locate with A&E. Following the Forum's challenge of this decision it was agreed that the service should co-locate with ECC at KCH and that a weekend service should remain at Herne Bay subject to a 6 month review.

- Co-location took place in September 2006 and the 6 month review has now been completed and following joint work between Stourcare and the Forum the PCT agreed on 27 March 2007 to the recommendation to maintain the status quo i.e. a main OOHS service co-located with ECC at KCH and a weekend service at Herne Bay.

- Although we have now reached a satisfactory conclusion for the people of Herne Bay and Whitstable the Forum felt that:-

    a) you ought to be acquainted with the full details
    b) the value of joint working between Forum and OSC should be highlighted and
    c) you should be aware that a full review of the OOHS covering the new PCT catchment area will take place in 2008, the existing contractors i.e. Stourcare, MEDDOC and South East Coast having had their contracts extended to 31 March 2008 to accommodate this process.

2. Background

2.1 In January 2005 East Kent Coastal PCT and Canterbury and Coastal PCT signed a contract with Stourcare Ltd to provide out of hours medical services in the catchment areas covered by both PCTs. This replaced the service previously supplied by CANDOC which was run by local GPs and based at Chestfield Medical Centre.

2.2 The contract is particularly relevant and it is worth highlighting at this stage the

following pertinent paragraphs:-

Section 3 The Specification at paragraph 1 lists *Queen Victoria Memorial Hospital (QVMH) Herne Bay, Manston, Buckland Hospital Dover and Victoria Hospital Deal.*

Para 1.1 as a continuation of the list of premises says *Queen Elizabeth Queen Mother (QEQM), Margate and Kent and Canterbury Hospital (KCH) and other sites agreed between the PCT and contractor within the first year of operation*.

Paragraph 6.4.1 under the heading of services says *the contractor will open a second base for Canterbury residents at KCH and QEQM within the first year of the contract*

Paragraph 4.1 of Quality Standards says that *"The contractor will provide adequate primary care facilities to ensure that at least 85% of the patient population shall be within 30 minutes car traveling time to their closest base during evenings and weekends and 45 minutes care traveling time overnight*.*"*

2.3 Initially services were run from QVMH Herne Bay, Manston, Buckland Hospital and Victoria Hospital Deal but during 2006 medical services were moved from Manston to Queen Elizabeth Queen Mother Hospital Margate; the administrative base remaining.

2.3 In September 2005, as part of the Forum's ongoing partnership or should that be critical friend of the PCT and Stourcare it was stated, for the very first time, that the base at Herne Bay would close and the OOHS move to KCH to co-locate with A&E.

2.4 As this was the first the Forum had learned of these plans we voiced our concerns but the point was made by the PCT that the plan had only ever been to cover one site.

2.5 As this was contrary to information we had received and contrary to the terms of the Contract we asked the PCT for an explanation and were told that and I quote:-

"it was clearly unfortunate that the contract with Stourcare does not reflect the intentions of the PCT" and that *"it was always the intention that the base at Herne Bay should transfer to KCH…..". "This is in line with our strategic intentions for unscheduled care services".*

But the then CE went on to say that he accepted that there was legitimate expectation that the base in Herne Bay would remain and invited the Forum to participate in a review of OOHS with respect to activity levels, patient access and cost. At the same time he added that pending the outcome of the review there would be no change to the current service.

3. Co-location Review

3.1 The Forum has participated in the Review which started in January 2006 as a demonstration of our good faith and of our desire to co-operate and endorsed the recommendations that emerged in April/May that:-

- the PCT Board should review its decision to close the base at Herne Bay.
- co-location to Emergency Care Centre at KCH takes place as soon as possible
- a weekend service remains at Herne Bay.

But, and most critically the service should be formally reviewed after 6 months.

3.2 This endorsement was pragmatically based recognising the need to obtain statistical evidence of the impact of the change to inform future decisions. And acknowledged that co-location of unscheduled care services was recommended as best practice by DoH and part of the PCT's strategic plan.

3.3 However, the Forums involvement was without prejudice to any action that we considered was necessary regarding the Contract. Although, we did and still do appreciate the co-operation we had received and hopefully the partnership that has developed between ourselves, the PCT and Stourcare.

3.4 Unfortunately the Forum has no legal power to challenge the legality of action under a contract and acting on advice from Commission for Patient and Public Involvement in Health we referred the matter to the OSC. Hence your involvement in April 2006.

4. Co–Location

4.1 Following the co-location of the existing out-of-hours clinical services provided by StourCare at the QVMH, Herne Bay, to the KCH, Canterbury on 20 September 2006, a six month pilot project was undertaken to determine whether a clinical base service should remain on the coastal strip during the weekend and bank holiday periods. This project extended the level of clinical cover provided on weekends and bank holidays (courtesy of the former PCT, Canterbury and Coastal PCT) who funded two four hour GP sessions between the period of 09:00 and 17:00 on each respective day. These sessions are supported by a receptionist and this service works in partnership with the GP and Driver Team who, externally to this project, were retained within the coastal area in order to be able to effectively respond to home visits.

The six month pilot came to a close on 31.3.07. At the request of the PCT, the Forum worked jointly with Stourcare in establishing a method of study. All patients who proceeded to any point in Stourcare's treatment, beyond advice, were relevant to our study. This enabled the capture of:-

- Requests by clinician to attend base – accepted by the patient
- Requests by clinician to attend base – declined by the patient
- Patients who decline further treatment
- Patients who require home visits
- Patients who receive a home visit at the discretion of the GP due to the refusal to attend base

This was achieved through:-

- Statistical Analysis;

- Patient Feedback (Patient Satisfaction Questionnaire's); and,
- Monitoring of Complaints.

There were four periods of study all lasting for one month which provided: a benchmark through the assessment of the state prior to co-location; and, an assessment of the state post co-location. At the end of the pilot both Stourcare and the Forum made independent submissions to PCT and made recommendations for the future.

5. Outputs and Findings from Study

5.1 The following comments are on the Forum's observations and submission and the recommendations submitted to the PCT by Stourcare. Firstly the hard data:-

Evidence based data

5.2 One of the most revealing statistics is that for base appointments for the whole week which shows that 255 patients attended Herne Bay in Oct/Nov 06 of whom 132 were from Herne Bay, 83 from Whitstable and 40 from Canterbury out of a total of 668 who were dealt with by Stourcare ie 38% of total numbers. Or in other words 75% of Herne Bay patients went to Herne Bay base and 25% went to Canterbury; 61% from Whitstable went to Herne Bay compared to 39% who attended Canterbury base.

5.3 Alternatively from the PIE charts we can see that of the total patients who attended a base 58% went to Canterbury and 40% went to Herne Bay (Dover and Thanet figures are negligible). And, the percentages in favour of the latter are even more marked when we compare the figures on a pro rata basis as we understand Canterbury's attendance numbers are spread over a period of 118 hours while those for Herne Bay are for only 32 hours. In other words very nearly four times as many people might have attended Herne Bay base if the service had been available on an equal basis to Canterbury.

Patient Satisfaction Questionnaire

5.4 A Patient Satisfaction Questionnaire was produced to further inform our monitoring process with questions relevant to the project. The data collection methods employed ensured that all patients attending a base consultation received a questionnaire and a PSQ was also sent to a random selection of those patients who contacted our service but did not attend base. The completion of the PSQ was not compulsory and sadly resulted in a very low response of 4.6% but nonetheless shows that some patients from the Herne Bay and Whitstable areas still choose to use the base at Herne Bay because it is more local to their homes.

5.5 It is also interesting to note that opening the base at Canterbury and leaving a limited service in Herne Bay has had little or no effect on the number of home visits to either Herne Bay or Whitstable; the figures for October 2006 are virtually the same as the same period in 2005.

Complaints

5.6 There were no complaints received by Stourcare during the study period which

relate to the remodelling of this service.

Other information - demography

5.7 The coastal area is populated by a considerable number of older people. The access to local care and the need for social support required by these patients is considerably greater at times of ill health, especially those that live alone and/or are unsupported by friends or family who live locally.

Access

5.8 During the weekday period patients from the coastal area said that travel times were less than 30 minutes and they did not have difficulty in travelling to the KCH. But the 5 responses received from those patients who live in the coastal area, all indicated that they would have preferred to have attended the QVMH rather than the KCH because they found the QVMH more accessible, with neighbours/friends being more willing to drive patients this shorter distance.

5.9 Stourcare's have pointed out that their Contract/Service Level Agreement states that: "*the contractor will provide adequate primary care facilities to ensure that at least 85% of the patient population shall be within 30 minutes car travelling time to their closest base during evenings and weekends and 45 minutes car travelling time overnight*." They acknowledged that during the weekday period travelling to the KCH is achievable within these guidelines, but say that weekend travel to the KCH for those patients residing on the coastal strip would fall outside of these guidelines.

5.10 Stourcare also indicated that without the base service at QVMH, the subsequent increase in travelling time for patients could result in an increased number of complaints which might reduce their effectiveness and efficiency as a consequence of an increased demand on home visits. This shift in working pattern could result in StourCare not being able to achieve its quality standards as the rise in home visits on the coastal strip could increase by up to 30 a day over the weekend and bank holiday periods.

Patient Choice and NHS reform

5.11 Stourcare also highlighted the fact which the Forum supports that the reforming of the NHS to be more responsive to patients' needs has established, through the NHS plan and public consultations (such as Our Health, Our Care, Our Say), that care needs to be accessible, faster and more convenient to where people live. Patients are said to experience better health outcomes when they are more involved in the decisions on where treatment is accessed. Patients residing on the coastal strip will not have any choice as to where to receive primary care out of hours if there is only a KCH option available and this also contradicts the principle of care being closer to home.

Additional factors from Stourcare

5.12 Finally, in their submission Stourcare pointed out that:-

a) East Kent is a Department of Health Demonstration Site for Urgent Care. This process is radically reviewing all aspects of the urgent care pathway. Out of Hours services are a key part of this process of review and it may be

considered appropriate to wait until the new service model has been proposed before any significant change is recommended.

(b) from the 1^{t} April 2007, StourCare will have only one year remaining on its contract

c) discussions are underway for their co-located centre at the KCH to expand its role in supporting the Hospital Trusts' Minor Injury Unit and the removal of the additional service could adversely affect Stourcare's ability to support this, and subsequent, service improvement(s).

6. Recommendations

6.1 Both the Forum's and Stourcare's recommendations to the PCT based on the above were to maintain the status quo. In other words:-

- **Retain Visiting GP & Driver Team at Herne Bay**
- **Retain Current Base Service at Herne Bay: Weekends and Bank Holidays**

6.2 At the Review Group meeting on 23 March 2007 the PCT tentatively accepted these recommendations and formal acceptance was received a few days later on 27 March 2007.

7. Conclusion

7.1 Thank you for giving me the opportunity to cover this topic in the depth it deserves. Although we have now reached a satisfactory conclusion for the people of Herne Bay and Whitstable, from the Forum's perspective it demonstrates that without our intervention and your (OSC)involvement the following would have occurred:-

- an apparent legal contract can be put to one side and the recommendations ignored; in fact dismissed as never being the original intention
- people of the coastal areas would have been disadvantaged
- closure would have occurred without any apparent consultation with patients or public.

7.2 On the other hand it also demonstrates that with the subsequent consultation a satisfactory partnership between PCT, contractors and the Forum can be achieved to ensure patients and public get the service they need. It also shows the value of joint working between Forum and OSC.

7.3 And finally as I mentioned when I first started we need to be aware that a full review of the OOHS covering the new PCT catchment area is scheduled to take place in 2008 and both Forum, OSC and patients and public should be involved from the start in the consultation process.

Peter Robinson
Forum Member & OOHS Lead
Canterbury & Coastal Locality Group
Eastern & Coastal Patient & Public Involvement Forum 5/06/2007

Appendix 1 - Patient Questionnaire

We are undertaking some analysis on patients' access to our bases. We would be very grateful if you would be willing to answer the questions below. Your comments will be kept in confidence and you are not obliged to disclose your identity. Should you choose to disclose your identity, any analysis conducted as a result of this survey will not be identifiable to you personally, nor will your identity be disclosed to any person or organisation outside of StourCare.

Your Name: (Optional) _____

If you are the patient, please fill in the details below:

If you are not the patient please give the patient's details.

Age:		
	Male	Female
Gender:		

Post Code:	

	Please Tick √ Yes	No
On contacting StourCare, were you given clear instructions on how to find us?		
Did you use your own vehicle?		
Did a relative, friend or neighbour drive you to the base?		
If applicable, were parking facilities available to you?		
Were the parking facilities close to the place that you saw the doctor?		
Did you use public transport?		
Was the public transport adequate?		
Did you travel by taxi?		
Did your journey take :		
• 45 minutes or less overnight (i.e. 2300 – 0800)		
• 30 minutes or less in the evening (i.e. 1830 – 2300)		
• 30 minutes or less at weekends (i.e. 0800 – 1830)		
If outside these travel time ranges, how long did your journey take you?		

Which base did you attend?	Margate	
	Canterbury	
	Herne Bay	
	Dover	
	Deal	
Why did you choose this base?		

What time of day (approximately) did you initially contact the StourCare service?		
Was it a weekday or weekend?		
Were you offered an earlier appointment than the one that you attended?	Yes	No
Can you remember the time of the earliest appointment that you were offered?	Yes	No
If so, when?		

Is there anything else you would like to add in relation to the questions asked above?

Thank you very much for participating in this survey. Your comments are valuable to us in our aim to continually improve the services that we offer.

20/06/2005 - 20/07/2005 =	**A1**	A1 & B1 are 2005. A2/B2 are 2006.
20/10/2005 - 20/11/2005 =	**B1**	A2/B2 are pre and post co-location, A1/B1 are just there to show
20/06/2006 - 20/07/2006 =	**A2**	the same time period the previous year.
20/10/2006 - 20/11/2006 =	**B2**	

Base Appointments - Weekdays Only

Pre Co-location

A1	From HB	From Whit	Combined	Total
at Herne Bay base	84	47	131	196

% of HB base appts. from HB/Whit area: **66.8%**

B1	From HB	From Whit	Combined	Total
at Herne Bay base	43	26	69	120

% of HB base appts. from HB/Whit area: **57.5%**

A2	From HB	From Whit	Combined	Total
at Herne Bay base	58	33	91	154

% of HB base appts. from HB/Whit area: **59.1%**

Post Co-location

B2	From HB	From Whit	Combined	Total
at Canterbury base	12	33	45	132

% of Cant base appts from HB/Whit area: **34.1%**

July-June	2005 (**A1**)	2006 (**A2**)	Variance	% change
Base appts.(HB & Cant.)	131	91	-40	**-30.5%**

Oct-Nov	2005 (**B1**)	2006 (**B2**)	Variance	% change
Base appts.(HB & Cant.)	69	45	-24	**-34.8%**

Home Visits - Weekdays Only

Pre Co-location

A1	To Cant.	To HB	To Whit.	Combined	Total
	68	43	26	137	153
% of total -	44.4%	28.1%	17.0%		

B1	To Cant.	To HB	To Whit.	Combined	Total
	54	32	32	118	134
% of total -	40.3%	23.9%	23.9%		

A2	To Cant.	To HB	To Whit.	Combined	Total
	51	38	26	115	123
% of total -	41.5%	30.9%	21.1%		

Post Co-location

B2	To Cant.	To HB	To Whit.	Combined	Total
	33	35	31	99	132
% of total -	25.0%	26.5%	23.5%		

July-June	2005 (**A1**)	2006 (**A2**)	Variance	% change
Home visits (HB & Cant.)	137	115	-22	**-16.1%**

Oct-Nov	2005 (**B1**)	2006 (**B2**)	Variance	% change
Home visits (HB & Cant.)	118	99	-19	**-16.1%**

20/06/2005 - 20/07/2005 =	**A1**	A1 & B1 are 2005. A2/B2 are 2006.
20/10/2005 - 20/11/2005 =	**B1**	A2/B2 are pre and post co-location, A1/B1 are just there to show the
20/06/2006 - 20/07/2006 =	**A2**	same time period the previous year.
20/10/2006 - 20/11/2006 =	**B2**	

Base Appointments - Entire Week

Pre Co-location

A1	From HB	From Whit	Combined	Total
at Herne Bay base	262	163	425	723

% of HB base appts. from HB/Whit area: **58.8%**

B1	From HB	From Whit	Combined	Total
at Herne Bay base	232	165	397	679

% of HB base appts. from HB/Whit area: **58.5%**

A2	From HB	From Whit	Combined	Total
at Herne Bay base	174	121	295	519

% of HB base appts. from HB/Whit area: **56.8%**

Post Co-location

B2	From HB	From Whit	Combined	Total
at Herne Bay base	132	83	215	255

% of HB base appts from HB/Whit area: **84.3%**

B2	From HB	From Whit	Combined	Total
at Canterbury base	43	54	97	413

% of Cant base appts from HB/Whit area: **23.5%**

July-June	2005 (A1)	2006 (A2)	Variance	% change
Base appts.(HB & Cant.)	425	295	-130	**-30.6%**

Oct-Nov	2005 (B1)	2006 (B2)	Variance	% change
Base appts.(HB & Cant.)	397	312	-85	**-21.4%**

Home Visits - Entire Week

Pre Co-location

A1	To Cant.	To HB	To Whit.	Combined	Total
	189	93	77	359	414
% of total -	45.7%	22.5%	18.6%		

B1	To Cant.	To HB	To Whit.	Combined	Total
	190	117	93	400	451
% of total -	42.1%	25.9%	20.6%		

A2	To Cant.	To HB	To Whit.	Combined	Total
	129	93	65	287	318
% of total -	40.6%	29.2%	20.4%		

Post Co-location

B2	To Cant.	To HB	To Whit.	Combined	Total
	143	120	91	354	405
% of total -	35.3%	29.6%	22.5%		

July-June	2005 (A1)	2006 (A2)	Variance	% change
Home visits (HB & Cant.)	359	287	-72	**-20.1%**

Oct-Nov	2005 (B1)	2006 (B2)	Variance	% change
Home visits (HB & Cant.)	400	354	-46	**-11.5%**

Patient Call Trends 2005 & 2006

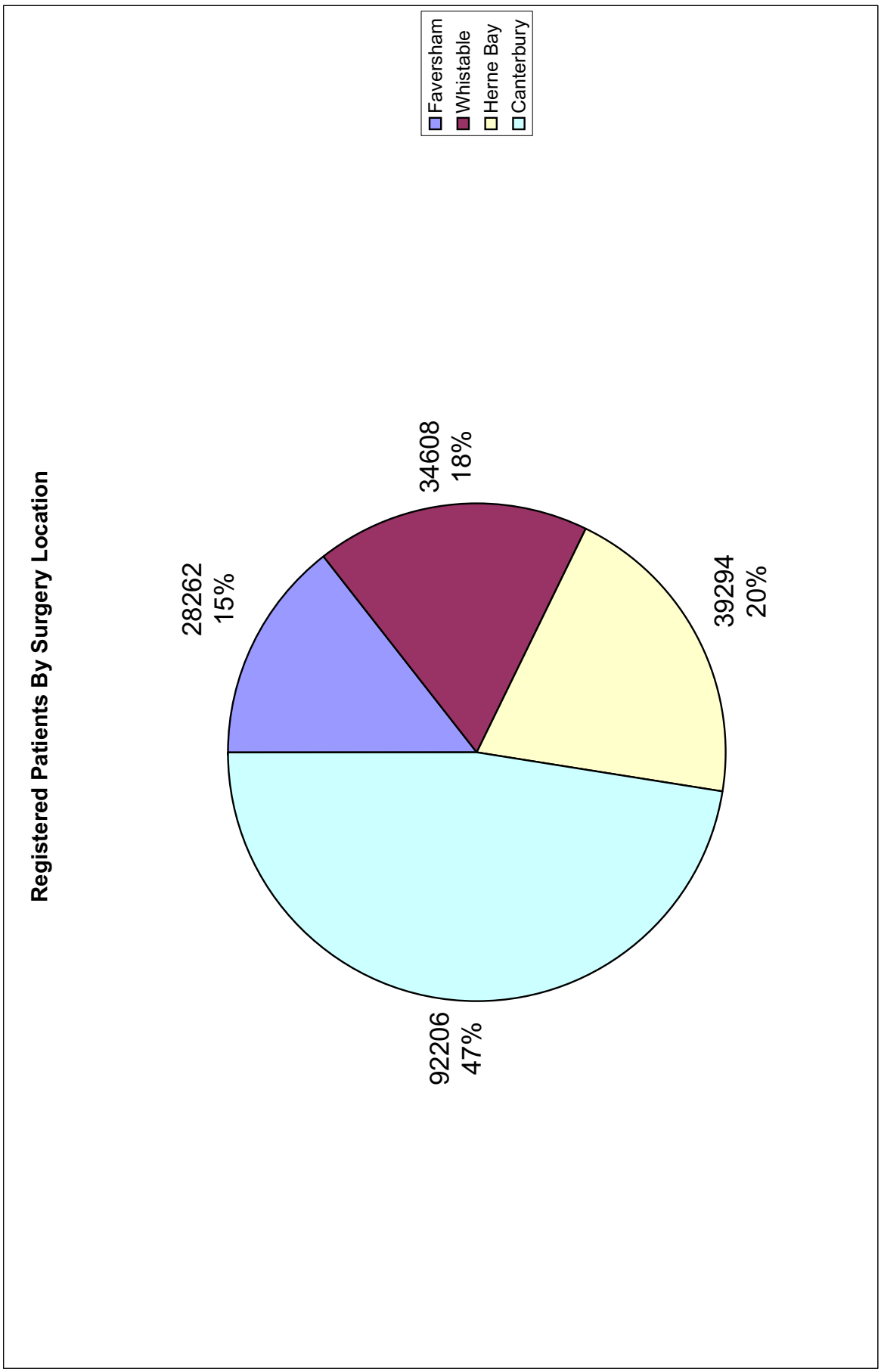
	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Total
Base appts	3363	2457	3165	2481	2966	2171	2394	1972	1764	2113	1658	2388	28892
Home visits	1454	969	1208	1028	1095	750	915	780	796	929	885	1047	11856
Other	3387	3000	3458	3092	2961	2485	2663	2857	3116	3762	3440	4675	38896
Total	8204	6426	7831	6601	7022	5406	5972	5609	5676	6804	5983	8110	79644

	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Total
Base appts	2249	1842	1676	2194	1961	1476	1756	1365	1419	1546	1422	2343	21249
Home visits	976	781	829	928	865	756	800	755	736	762	661	978	9827
Other	4374	4095	4060	4510	3739	3150	3576	3326	3270	3499	3161	4612	45372
Total	7599	6718	6565	7632	6565	5382	6132	5446	5425	5807	5244	7933	76448

Comparison:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Base appts	-1114	-615	-1489	-287	-1005	-695	-638	-607	-345	-567	-236	-45	-7643
Home visits	-478	-188	-379	-100	-230	6	-115	-25	-60	-167	-224	-69	-2029
Other	987	1095	602	1418	778	665	913	469	154	-263	-279	-63	6476
Total	-605	292	-1266	1031	-457	-24	160	-163	-251	-997	-739	-177	-3196

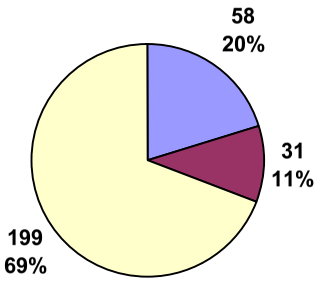
Comparison %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Base appts	-33.1%	-25.0%	-47.0%	-11.6%	-33.9%	-32.0%	-26.6%	-30.8%	-19.6%	-26.8%	-14.2%	-1.9%	-26.5%
Home visits	-32.9%	-19.4%	-31.4%	-9.7%	-21.0%	0.8%	-12.6%	-3.2%	-7.5%	-18.0%	-25.3%	-6.6%	-17.1%
Other	29.1%	36.5%	17.4%	45.9%	26.3%	26.8%	34.3%	16.4%	4.9%	-7.0%	-8.1%	-1.3%	16.6%
Total	-7.4%	4.5%	-16.2%	15.6%	-6.5%	-0.4%	2.7%	-2.9%	-4.4%	-14.7%	-12.4%	-2.2%	-4.0%

"Other" includes 999, A+E, DN Messages, Doctor Advice, and Nurse Advice

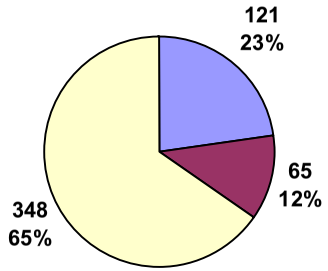

Registered Patients By Surgery Location
Faversham
Whistable
Herne Bay
Canterbury
28262
15%
34608
18%
39294
20%
92206
47%

Pre Co-Location 20/10/2006-20/11/2006

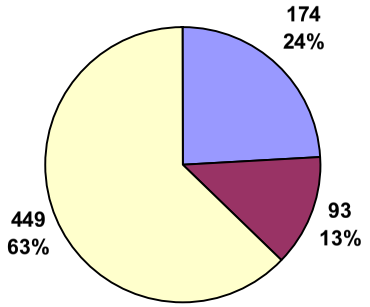
Faversham Patient Contacts



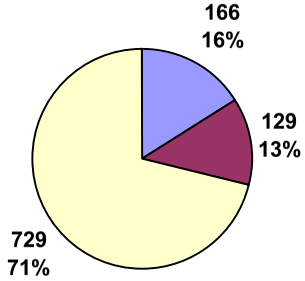
Whitstable Patient Contacts

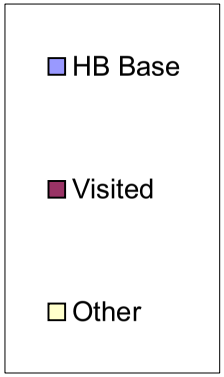


Herne Bay Patient Contacts

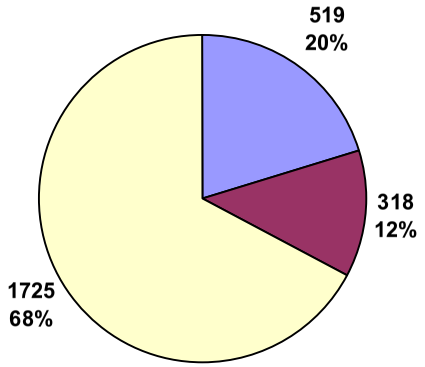


Canterbury Patient Contacts





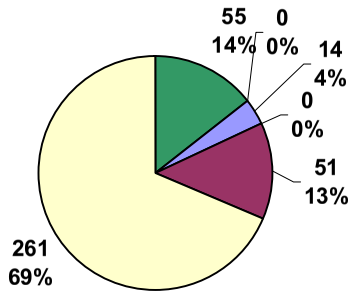
C&C PCT Locality Patient Contacts



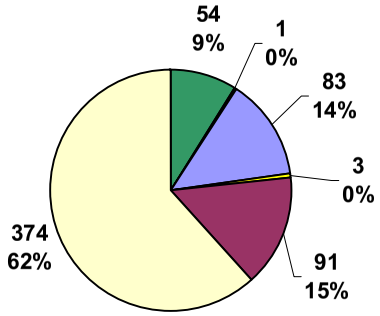
"Other" includes 999, A+E, DN Messages, Doctor Advice, and Nurse Advice

Post Co-Location 20/10/2006 - 20/11/2006

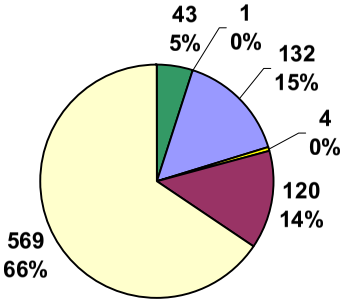
Faversham Patient Contacts



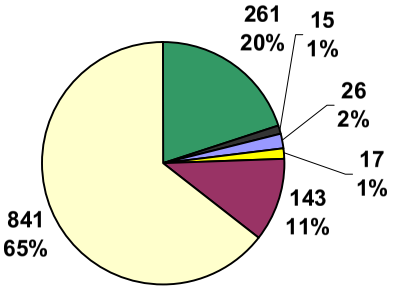
Whitstable Patient Contacts

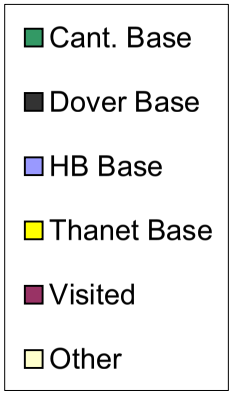


Herne Bay Patient Contacts

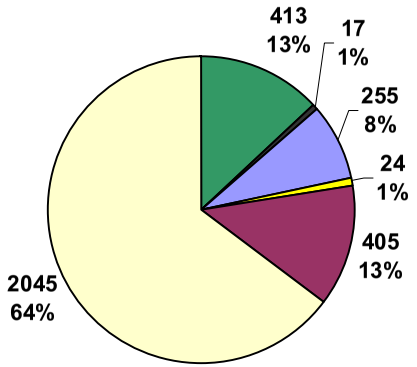


Canterbury Patient Contacts





C&C PCT Locality Patient Contacts



"Other" includes 999, A+E, DN Messages, Doctor Advice, and Nurse Advice

Appendix C - Patient Questionnaire

We are undertaking some analysis on patients' access to our bases. We would be very grateful if you would be willing to answer the questions below. Your comments will be kept in confidence and you are not obliged to disclose your identity. Should you choose to disclose your identity, any analysis conducted as a result of this survey will not be identifiable to you personally, nor will your identity be disclosed to any person or organisation outside of StourCare.

Your Name: (Optional) _____

If you are the patient, please fill in the details below:

If you are not the patient please give the patient's details.

Age:		
	Male	Female
Gender:		
Post Code:		

	Please Tick √ Yes	No
On contacting StourCare, were you given clear instructions on how to find us?		
Did you use your own vehicle?		
Did a relative, friend or neighbour drive you to the base?		
If applicable, were parking facilities available to you?		
Were the parking facilities close to the place that you saw the doctor?		
Did you use public transport?		
Was the public transport adequate?		
Did you travel by taxi?		
Did your journey take :		
• 45 minutes or less overnight (i.e. 2300 – 0800)		
• 30 minutes or less in the evening (i.e. 1830 – 2300)		
• 30 minutes or less at weekends (i.e. 0800 – 1830)		
If outside these travel time ranges, how long did your journey take you?		

Which base did you attend?	Margate	
	Canterbury	
	Herne Bay	
	Dover	
	Deal	
Why did you choose this base?		

continued overleaf/…

What time of day (approximately) did you initially contact the StourCare service?		
Was it a weekday or weekend?		
Were you offered an earlier appointment than the one that you attended?	Yes	No
Can you remember the time of the earliest appointment that you were offered?	Yes	No
If so, when?		

Is there anything else you would like to add in relation to the questions asked above?

Thank you very much for participating in this survey. Your comments are valuable to us in our aim to continually improve the services that we offer.

Item 5

General Pharmaceutical Services

Pharmaceutical services within the NHS

Pharmacists are trained, qualified and registered healthcare professionals who practise the art and science of pharmacy, i.e. the dispensing to patients of drugs/medicines and appliances.

Under the Medicines Act 1968 there are three legal categories of medicines:

- General Sales List (GSL) Medicines – which can be freely sold over-the-counter and are available in a wide range of retail outlets;
- Pharmacy-only (P) Medicines – which can be sold over-the-counter but may only be dispensed by, or under the supervision of, a registered pharmacist;
- Prescription-Only Medicines (POMs) – which must be prescribed for a named patient by an appropriately registered healthcare professional and dispensed by, or under the supervision of, a registered pharmacist.

In NHS hospitals, the dispensing role is fulfilled by hospital pharmacies, which are staffed by pharmacists working as salaried NHS staff. In NHS community services, it is mainly fulfilled by General Pharmaceutical Services, provided through independent contractors (community pharmacies), as has been the case since the inception of the NHS in 1948. The total number of NHS community pharmacies in England at 31 March 2006 was 9,872.

In certain designated (mainly rural) areas that lack easy access to a community pharmacy, GP practices can be permitted (subject to certain criteria) to dispense NHS prescriptions.

Prescriptions are written by doctors and dentists, and (since 2003) by some nurses and pharmacists who act as “supplementary prescribers” in respect of a limited range of medicines. Doctors and dentists are also able to administer drugs to patients at the time of treatment.

In *Pharmacy in the Future – Implementing the NHS Plan* (2000), the government envisaged a key role for pharmacy services in the new “high quality, patient-centred health service”, and committed itself to change and modernisation in various respects.

Prescription charges

Drugs, medicines and appliances that are dispensed in NHS hospitals are provided free-of-charge. This was initially also the case in respect of primary-care prescriptions. However, flat-rate, per-item patient charges were agreed in 1951 and introduced the following year, in order to raise revenue and limit demand (chiefly the latter).

Prescription charges have remained ever since in England and have risen every year since 1982. The current charge is £6:85 per item. Exemptions from charges apply to the following groups:

- children aged under 16;
- young people aged 16, 17 and 18 in full-time education;
- people with certain medical conditions;
- people aged 60 and over;
- women who are pregnant and those who have given birth within the past 12 months;
- people on benefits / a low income (as defined in regulations);
- war pensioners whose prescription is for their accepted disablement.

In addition, Prescription Pre-payment Certificates (a form of prescription "season ticket") help people who require multiple prescriptions to reduce the cost if they are not entitled to free prescriptions on other grounds.

Around 87% of prescription items in England are dispensed free-of-charge, a proportion that has remained fairly constant in recent years.

Prescription charges are expected to raise some £425 million for the NHS in 2007–8; this is, however, a very modest sum when set against the total cost of drugs provided by NHS community pharmacy services (see below).

In October 2006 the Department of Health announced an internal review of patient charges and exemption arrangements for the NHS in England, with a brief to consider "cost-neutral" options for reform of patient charges. This was in response to a report by the House of Commons Health Select Committee on patient charges that described current charging arrangements as "a complete mess". The outcome of the internal review is due to be reported to Parliament shortly.

The cost of drugs to the NHS

The "pharmaceutical revolution" of the 1950s and 1960s saw the development of more, and better, drug-based treatments than had hitherto been available. This led to a sharp increase in the NHS primary-care drugs bill, with the cost of community pharmaceutical services overtaking, and then significantly exceeding, the cost of General Medical Services (provided by GPs). The pace of pharmaceutical innovation has quickened ever since, with the consequent inexorable rise in drug costs posing a constantly escalating challenge to NHS finances.

This trend is now being exacerbated by the current growth in the population of older people, which adds significantly to the number of people with both acute and chronic conditions that are amenable to drug-based interventions.

Expenditure on drugs in primary care has increased by some 60% in real terms over the past decade, while the number of items dispensed has increased by 55%. The five years prior to 2005 saw average annual growth of 7.3% in the cost of community prescribing. The rising cost of drugs (in hospitals and in primary care) has absorbed a significant proportion of the additional money that has been put into the NHS by the government in recent years.

Some 752 million prescription items were dispensed in the community in England in 2006 (up 4.4% on the previous year). The cost of these items was £8.2 billion (equivalent to £22 million per day), representing a rise of 3.8% on the previous year.

While advances in pharmaceutical technology and demographic change both make it inevitable that NHS drug costs will continue to rise for the foreseeable future, it is evident that there is scope to blunt this trend somewhat by obtaining better value for money.

NICE guidance

The National Institute for Health and Clinical Excellence (NICE) produces guidance with the aim of ensuring that there is consistent prescribing of effective, and cost-effective, drugs throughout the NHS.

However, there is still perceived to be a "postcode lottery" in prescribing, driven by the different financial situations in which local NHS Primary Care Trusts find themselves. The provision of drugs prescribed by GPs does not have ring-fenced funding attached to it. Rather, it must be financed by PCTs from their "unified allocations", out of which hospital, community and primary-care medical services are also funded.

The situation is complicated by: the fact that NICE's findings are disputed by pharmaceutical companies; the time that it takes NICE to evaluate new drugs; and the trend towards litigation by some patients.

Other scope for savings

The latter part of 2005 and the first half of 2006 actually saw marginal falls in the cost of NHS prescribing in primary care. This one-off period of falling costs, against the long-term trend, has been attributed to the operation of the Pharmaceutical Price Regulation Scheme (PPRS) and greater use of generic drugs (chemical equivalents of expensive, heavily-advertised, brand-name products).

In February 2007, the Office of Fair Trading (OFT) published a report on the PPRS. The OFT recommended that the current "profit cap and price-cut" scheme be replaced with a value-based pricing scheme, in which the price paid by the NHS for medicines would reflect the therapeutic benefits they brought to patients. It was estimated that a value-based scheme could release over £600 million per year. The government is currently considering its response to the OFT report.

In May 2007, the National Audit Office (NAO) published a report on *Prescribing costs in primary care*. The NAO found that there was significant potential for achieving better value for money in primary-care prescribing. It was argued that PCTs could save more than £200 million, without affecting clinical outcomes, through more efficient prescribing.

Better prescribing, as already undertaken in a small number of PCTs, in respect of just four drug-therapies (statins, renin-angiotensin drugs, clopidogrel and proton

pump inhibitors – which together account for a fifth of the community prescribing bill) could have saved £227 million across England in 2006–7.

The NAO said that improving efficiency and effectiveness would entail changing the prescribing behaviour of some GPs. It was found that high-prescribing GPs tended to be strongly influenced by marketing messages directed at them by the pharmaceutical industry. The NAO noted that drug companies spent £850 million each year marketing their products to GPs. (A further complicating factor in future could be the advertising of drugs direct to the public. This is not currently permitted, but the European Union is reportedly looking at the possibility of relaxing restrictions on such advertising.)

The NAO report stated that Practice-based Commissioning (which involves giving GPs control over the healthcare budgets for their patients) could be a lever for improving value for money in drugs expenditure – although this potential had yet to be tested.

Drugs wastage (i.e. the dispensing of drugs that go unused by patients, for a variety of reasons) was identified by the NAO as a significant, but (to an extent) potentially avoidable, cost to the NHS.

It is hoped the data that will be produced by the Electronic Prescriptions Service (which is being implemented as part of the £12 billion NHS IT programme) will enable prescribing patterns to be analysed systematically and critically in future.

General Pharmaceutical Services contract

PCTs commission community pharmacy services from pharmacists and dispensing GP practices. These service providers are paid on behalf of PCTs by the Prescription Pricing Division of the NHS Business Services Authority (formerly the Prescription Pricing Authority). Providers are reimbursed for the cost of the drugs and appliances they supply (plus fees for each item dispensed and a professional allowance), according to rates set out in the monthly Drug Tariff.

Community pharmacies are contracted by PCTs to supply services in accordance with a statutory scheme, under terms of service that are set out in regulations.
Under current arrangements (introduced in 2005), services provided by community pharmacies are divided into three categories:

1) **"Essential Services"** must be provided by all community pharmacies. These include:

    - dispensing pharmaceuticals;
    - repeat dispensing (reducing the need for patients to visit their GP to obtain further prescriptions);
    - disposing of returned or unused medicines;
    - promotion of healthy lifestyles (particularly among at-risk groups, such as obese people);
    - advice on self-care for patients with minor or chronic illnesses;
    - "signposting" patients to other healthcare services.

2) **"Advanced Services"** require both the pharmacist and the pharmacy premises to be accredited for the provision of certain services. The first of these services that are being provided is the undertaking of "Medicines Use Reviews" (MURs). These are periodic discussions with patients to check their compliance with prescribed treatment and discuss any problems they have with their medication. The expected benefits of MURs include a reduction in drug wastage.

3) **"Enhanced Services"** can be commissioned by PCTs from community pharmacies to meet the needs of particular local populations. These services include the following:

    - Anticoagulant Monitoring;
    - Care-Home services;
    - Disease-Specific Medicines Management;
    - Gluten-Free Food Supply;
    - Home Delivery;
    - Language Access services for non-English speakers;
    - Medication Reviews;
    - Medicines Assessment and Compliance Support;
    - Minor Ailment Schemes;
    - Needle and Syringe Exchange for injecting substance-misusers;
    - On-Demand Availability of Specialist Drugs;
    - Out-of-Hours services;
    - Patient Group Directions (providing drugs to certain defined groups without individual prescriptions);
    - Prescriber Support (liaising with prescribers);
    - Schools services;
    - Screening for certain conditions;
    - Stop Smoking services;
    - Supervised Administration of certain drugs (e.g. the heroin substitute Methadone);
    - Supplementary Prescribing (over 500 pharmacists in England have now taken on the role of "supplementary prescriber").

These contract arrangements are intended to embody the principles set out by the Department of Health in *Choosing Health through Pharmacy* (2005). This set out a strategy whereby pharmacists in all sectors of the NHS (not just in the community) could help bring about the "health promoting NHS" referred to in the public-health White Paper *Choosing Health* (2004).

The new contract was welcomed by pharmacists for its recognition of their capacity to play a significantly enhanced role in the delivery of healthcare services. However, the Royal Pharmaceutical Society of Great Britain (RPSGB), which acts as the professional and regulatory body for pharmacists, is concerned that community pharmacists are finding it difficult to access funding from PCTs to provide extended (Advanced and Enhanced) services.

In addition to the national contractual arrangements, PCTs also have the option to commission under Local Pharmaceutical Services contracts, to provide certain services not traditionally associated with community pharmacies. There were said to

be around 270 such contracts in 2006, including some 230 under the Essential Small Pharmacies Scheme, providing additional financial support to pharmacies in areas where they might be unviable without subsidy.

"Control of entry" regulations

Originally, NHS community pharmaceutical services operated on an open-market basis. Pharmacies were able to provide services under contract to the NHS wherever they wished, meaning that community pharmacies were able to compete freely for NHS patients' business in a wholly unregulated environment.

However, the law governing the provision of community pharmaceutical services was changed in 1986. From the following year, the NHS had the ability to determine which "chemists" (a term covering both pharmacies and appliance contractors, who supply certain types of appliance) were given contracts to provide NHS services in each area.

This power to regulate NHS pharmacies through "control of entry" now resides with PCTs. In each case, the PCT must decide whether granting a pharmacy's application to supply NHS services is "necessary or desirable" in terms of securing adequate local provision of services.

In 2003, the OFT published a report, *The Control of Entry Regulations and Retail Pharmacy Services in the UK*, which recommended the total deregulation of NHS community pharmaceutical services. The OFT argued that restricted entry into the NHS pharmacy market acted as a restraint on competition, depriving consumers of choice and access.
According to the OFT, NHS dispensing accounted for 80% of a typical community pharmacy's revenues. There was a market for private prescriptions, but it was worth just £300 million a year across the whole UK, the OFT reported. Consequently, pharmacies without an NHS contract were seldom commercially viable – the OFT found that there were just 130 of these in the UK in 2003.

The OFT argued that deregulating NHS community pharmacies would lead to greater efficiency and innovation, as a result of more pharmacies opening and keener competition. In consequence, consumers would get better service and pay less for over-the-counter (GSL and P) medicines – and, ultimately, the NHS would get a better deal in the dispensing of POMs.

It was argued that the Essential Small Pharmacies Scheme and dispensing by rural GPs provided an adequate "safety net" for communities that might be poorly served by an unregulated market.

However, these conclusions were hotly disputed, not least by the RPSGB. Fears were expressed that complete deregulation would exacerbate the growing market strength of multiple pharmacy chains (see below), meaning that people living in less commercially attractive areas (such as deprived and rural areas) could suffer from reduced access to pharmacy services. This would particularly affect vulnerable people who were less able to travel, such as older people, socially excluded groups and people with chronic conditions.

It was argued that focusing on service-users as consumers, rather than as patients, would undermine the social function of community pharmacies – and cut across the government's aim to give pharmacies a greater role in health improvement, self-care and disease prevention.

A more competitive culture, it was argued, would undermine collaboration between pharmacists. This would cut across the government's aim for pharmacists to develop special interests and expertise, since pharmacists would be less inclined to refer patients to other pharmacists if they saw them chiefly as business rivals.

The government responded to the OFT report with what it called a "balanced package of reform measures". These were intended to open up the market and provide more convenient services through competition (as well as making regulation more business-friendly) – but without jeopardising the existing pharmacy network or causing widespread upheaval.

There were three strands to the government's reforms (which were introduced in 2005 – at the same time as the new General Pharmaceutical Services contract):

1) New criteria of choice and competition were introduced for the purposes of determining of whether it was "necessary or desirable" to grant an application for a contract.

2) Exemption from the "control of entry" requirements was granted for applications in respect of pharmacies that were:

    - located in shopping centres with over 15,000 sq metres of floorspace;
    - intending to open for more than 100 hours per week;
    - forming part of "one-stop" primary-care centres providing a range of NHS services;
    - wholly Internet or mail-order based (subject to the standard requirement to provide the full range of "Essential Services" under the NHS contract).

3) The operation of the regulatory system was reformed and modernised.

The rise of multiple pharmacy chains

There is a long-term trend of substantial growth in the proportion of community pharmacies within multiple chains (consisting of six or more pharmacies), which are owned by pharmacy companies and supermarkets. The proportion of community pharmacies in multiple chains increased from 38.6% in 1996–7 to 56.8% in 2005–6, with multiples exceeding independent pharmacies (single pharmacies and those in chains of up to five) for the first time in 2001–2.

The Department of Health stated in 2003 that the leading pharmacy chain (which was then Lloyds) held 10.9% of the market, while the top three companies (Lloyds, Boots and Moss) held 27.8% between them.

The merger of Boots with Alliance Unichem in 2006 led to the creation of a firm with a 17% share of the pharmacy market (dispensing 100 million NHS prescriptions each year), making it the new market leader. Alliance Boots is now the subject of a takeover bid by a private equity firm and concerns have been raised about the possible impact of this on NHS services.

Meanwhile, the government has given indications that it is keen to explore the idea of involving corporate High Street pharmacy chains in the delivery of a number of NHS services. In London, a pilot walk-in screening programme for the sexually-transmitted infection Chlamydia has been contracted out to 200 Boots stores. At Poole in Dorset, an NHS Healthcare Centre, providing a range of services, has been located by the local PCT in space rented within a Boots store. The Department of Health is keen to see similar arrangements elsewhere, involving Boots and also supermarket chains.

The future of community pharmaceutical services

In 2006, the government published a review of the impact of the revised "control of entry" regime. It showed that more than twice as many pharmacies had opened in 2005–6 than in any year in the period 1992–3 to 2004–5. The review found that deprived areas were neither significantly worse off nor significantly better off – although pharmacy closures in those areas were proportionally greater. PCTs with higher levels of social deprivation attracted proportionately more applications under the new exemptions, but evidence to show this would improve access was inconclusive.

Across the country, 99% of people were able to get to a pharmacy by car, walking or public transport within 20 minutes, including in deprived areas. There was evidence in some areas of pharmacies "leapfrogging" to secure the most advantageous commercial position. It was noted that there were more pharmacies near to GP surgeries than there had been in 2003.

The NHS had found the new regulations difficult to administer. It was stated that applications under the exemption provisions in particular had hampered efforts to plan strategically and commission more clinical services.

The government was sceptical about the suitability of the "control of entry" system as a means of enabling PCTs to play their commissioning role in respect of pharmaceutical services. It, therefore, announced a review to determine how to give PCTs "more powers to commission as is necessary to secure adequate service provision to meet local health needs, while ensuring that the opportunities to maximise choice and contestability within a reformed system are not lost".

Anne Galbraith, a lawyer and former chair of the Prescription Pricing Authority, was appointed to lead and chair the review. Her report will inform the government's next steps, which are expected to include a formal consultation.

The RPSGB has continued to oppose further deregulation, as well as expressing concern that the reforms already implemented (particularly the "control of entry" exemption for 100-hour pharmacies) are in danger of destabilising pharmacy services.

It has been suggested that further steps towards deregulation are inevitable, not least because of Article 14(5) of the proposed EU Services Directive, which is due to be implemented by 2010. This would have the effect of obliging the government to introduce complete deregulation of pharmaceutical services, in accordance with EU policy on free competition.

Provision of NHS community pharmacies in Kent and Medway / England, 2005–6

PCT area	Number of community pharmacies at 31 March 2006	Prescription items dispensed per month (000s), 2005–6	Population (000s), June 2003	Pharmacies per 100,000 population
Ashford	17	89	109	16
Canterbury and Coastal	30	174	167	18
Dartford, Gravesham and Swanley	42	236	223	19
East Kent Coastal	36	282	234	15
Maidstone Weald	33	234	239	14
Medway	47	258	262	18
Shepway	20	129	97	21
South West Kent	29	190	180	16
Swale	20	101	98	20
Totals:				
Kent and Medway	**274**	**1,692**	**1,610**	**17**
England	**9,872**	**54,914**	**50,093**	**20**

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

NHS community pharmacies in receipt of Electronic Prescriptions Service (EPS) payments, Kent and Medway / England, 2005–6

	Number of community pharmacies at 31 March 2006	Number in receipt of EPS payments	Proportion in receipt of EPS payments
Kent and Medway	274	3	1.1%
England	9,872	406	4.1%

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

Mean and median prescription items dispensed per month per pharmacy by NHS community pharmacies in Kent and Medway / England, 2004–5 and 2005–6

PCT area	Number of community pharmacies at year end (31 March)		Mean items per pharmacy		Median items per pharmacy	
	2004–5	2005–6	2004–5	2005–6	2004–5	2005–6
Ashford	15	17	5,459	5,206	4,312	4,695
Canterbury and Coastal	30	30	5,438	5,785	4,301	4,621
Dartford, Gravesham and Swanley	42	42	5,294	5,608	5,134	5,628
East Kent Coastal	36	36	6,892	7,820	6,154	6,803
Maidstone Weald	33	33	6,517	7,095	6,584	7,236
Medway	44	47	5,617	5,498	5,256	4,847
Shepway	20	20	6,159	6,447	6,219	6,584
South West Kent	28	29	6,234	6,552	5,940	6,028
Swale	19	20	5,007	5,064	4,557	4,055
Totals:						
Kent and Medway	267	274	5,846	6,119	5,256	5,628
England	9,736	9,872	5,331	5,563	4,733	5,301

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

NHS community pharmacies participating in scheme to collect and dispose of unwanted medicines, Kent and Medway / England, 2005–6

	Number of community pharmacies at 31 March 2006	Number in scheme	Proportion in scheme
Kent and Medway	274	273	99.6%
England	9,872	8,800	89.1%

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

NHS community pharmacies providing Medicine Use Reviews (MURs), Kent and Medway / England, 2005–6

PCT area	Number of community pharmacies at 31 March 2006	Number accredited to provide MURs	Proportion accredited to provide MURs	Number of MURs provided	Average number of MURs per accredited pharmacy
Ashford	17	7	41.2%	370	53
Canterbury and Coastal	30	13	43.3%	439	34
Dartford, Gravesham and Swanley	42	13	31.0%	339	26
East Kent Coastal	36	20	55.6%	260	13
Maidstone Weald	33	21	63.6%	720	34
Medway	47	13	27.7%	215	17
Shepway	20	9	45.0%	254	28
South West Kent	29	14	48.3%	488	35
Swale	20	5	25.0%	587	117
Totals:					
Kent and Medway	274	115	42.0%	3,672	32
England	9,872	3,842	38.9%	148,195	39

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

Potential savings through more efficient prescribing of statins, renin-angiotensin drugs, clopidogrel and proton pump inhibitors, Kent and Medway PCTs, 2006–7

Current PCT	Previous PCT (before October 2006)	Potential savings (£)
Eastern and Coastal Kent	Ashford	363,955
	Canterbury and Coastal	439,346
	East Kent Coastal	1,804,141
	Shepway	325,492
	Swale	413,987
Medway	Medway	867,830
West Kent	Dartford, Gravesham and Swanley	470,888
	Maidstone Weald	856,881
	South West Kent	1,301,914
Total:		**6,844,434**

Source: National Audit Office, *Prescribing costs in primary care* (2007)

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Providing NHS Pharmacy Services in Kent

Michael Keen,

Chief Executive Kent Local Pharmacy Committee

Local Pharmacy Committees

Topics I intend to cover today:

- What is a Local Pharmaceutical Committee?
- Where does it draw its powers from?
- How does pharmacy help to improve services to patients?
- How does pharmacy help public health?
- What is “Control of Entry?”

How Does Pharmacy Help Improve Services to Patients?

- Working with PCTs, providing commissioned services
- Ensuring equitable access to services
- The role of providers and types of pharmacy providers

Pharmacy and Public health?

- Providing a minimum standard of quality and monitoring through the national pharmacy contract
- NHS and Local Authorities working together – where does pharmacy fit?
- The Commissioning Framework for Health and Wellbeing
- The range of skills and services available

What is “Control of Entry?”

- How did we get to where we are?
- Possible reforms
- What does the public want?

Conclusion

We have today covered:

- Local Pharmaceutical Committees
- Pharmacy's role in improving services to patients
- Pharmacy and public health
- Control of entry

This is a very brief summary of where we are. Where do we go from here!

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Maidstone and Tunbridge Wells NHS
NHS Trust

REPORT TO: **Trust Board**

REPORT FROM: **Acting Director for Infection Prevention and Control**

DATE: **May 2007**

SUBJECT: **Quarterly Infection Control Report**

RECOMMENDATION: **For information**

SUMMARY:
This is the first quarterly infection control report. It is aimed to provide the Board with an overview of all infections which are reportable to the Health Protection Agency on a mandatory basis as well as briefing them of any other issues relating to infection control.

The report will include MRSA bacteraemia and Clostridium difficile against plotted against the set targets as well as GRE bacteraemias, surgical site infection surveillance, MRSA acquisition data, analysis arising from mortality review of patients medical records who have clostridium difficile and have died. The report will also include a summary of any outbreaks which have occurred and any actions taken as a result.

FIT WITH CORPORATE OBJECTIVES:

- To provide safe quality services and experience for patients, staff and the public
- To deliver services which are efficient and productive
- To ensure effective governance of the Trust and its services
- To ensure we are a model employer in the local community and within the NHS
- To deliver financial viability and sustainability

KEY RISKS:

- To ensure action plans are implemented to reduce HCAI – in particular MRSA bacteraemias and *Clostridium difficile*

ACTION REQUIRED:

- To receive the report and note it's contents

Quarterly Infection Control Report – January to March 2007

1. Introduction

The Infection Control Team (ICT) have reviewed their reporting systems. There is to be a monthly report for the Trust Board as part of the Integrated Governance report, which will include the incidence of Meticillin resistant *Staphylococcus aureus* (MRSA) positive blood cultures (bacteraemias) against the target and *Clostridium difficile* toxin associated diarrhoea against the locally set target. Data for patients who have had either infection and have died and this is entered on the death certificate either as a main cause of death or a contributory factor will also be collated. All patients who have died but where this is not identified on the death certificate will also be monitored as an indicator for action or response to action.

There will also be a quarterly report covering the time periods January to March, April to June, July to September and October to December for each year. These will plot the monthly figures together to aid with trend analysis. All other data which is reported on a mandatory basis to the Health Protection Agency will also be included – Glycopeptide-Resistant Enterococci (GRE) bacteraemias and Surgical Site Infection Surveillance for orthopaedic surgery. Results from the mortality review of medical records for patients who have *Clostridium difficile* and have died will also be included. The quarterly report will also include an overview of other issues relating to Infection Control as well as summarising the activities carried out by the ICT and progress against compliance with the Health Act (2006), and the annual forward plan for infection control.

2. Overview of Infection Control Activities

The focus for the Infection Control Team has been to continue the implementation of the Annual Infection Control Programme, in particular the concentration on the action plans for MRSA bacteraemia reduction and *Clostridium difficile* associated diarrhoea.

There have been five outbreaks of infection during this quarter as summarised below:

- January 2007 - *Clostridium difficile*, Kent & Sussex Hospital (SUI declared)
- February 2007 – Norovirus, Kent & Sussex Hospital, Wards 3, 5 and 11a
- March 2007 – Norovirus, Kent & Sussex Hospital, Ward 3
- March 2007 – Norovirus, Maidstone Hospital (SUI declared)
- March 2007 – *Clostridium difficile*, Maidstone Hospital, Foster Clark Ward (SUI declared)

A detailed summary of each outbreak is included further on in the report.

It should also be noted that patients with confirmed *Clostridium difficile* infection were cohorted again onto Whatman Ward, bay D and side rooms 3 and 4, as the number of patients with this infection remaining within the hospital had reached a point where side room flexibility had been lost.

3. HCAI Statistics

The mandatory reportable organisms to the Health Protection Agency are graphically represented below:

3.1 MRSA Bacteraemia

Bacteraemia occurs when bacteria get into the bloodstream. Bloodstream infection is also sometimes called septicaemia, which implies greater severity/clinical significance. A wide variety of bacteria can cause bacteraemias, the one of the most common being *Staphylococcus aureus.*

Staphylococcus aureus is a bacterium that is a common coloniser of human skin and mucosa. *Staphylococcus aureus* can cause disease, particularly if there is an opportunity for the bacteria to enter the body. Illnesses such as skin and wound infections, urinary tract infections, pneumonia and bacteraemia (blood stream infection) may then develop. It can also cause food poisoning. Most strains of this bacterium are sensitive to many antibiotics, and infections can be effectively treated. Some *S. aureus* bacteria are resistant to the antibiotic meticillin, termed meticillin-resistant *Staphylococcus aureus* (MRSA).

The mandatory *Staphylococcus aureus* bacteraemia surveillance scheme began in April 2001.

This scheme is operated by the Health Protection Agency on behalf of the Department of Health. Data are requested monthly and are entered onto a web-based reporting system, now called the HCAI enhanced surveillance system.

The following are collected as part of the surveillance scheme:

- Total blood culture sets examined (a sample arising from a single venepuncture, irrespective of the number of bottles tested)
- Total number of positive blood cultures (all positive results for bacterial growth, including repeat specimens and contaminants)
- Total meticillin-sensitive *S. aureus* (MSSA) bacteraemias
- Total meticillin-resistant *S. aureus* (MRSA) bacteraemias

Positive blood cultures from the same patient within 14 days of the initial culture are considered to be part of the original episode and should not be reported. Duplicate reports, more than 14 days apart should be reported as these are considered to be a separate episode.

	Total Blood Cultures Processed	Total Positive Blood Cultures (All organisms)	Total MSSA Positive Blood Cultures (Actual)	Hospital Acquired	Community Acquired	Total MRSA Positive Blood Cultures (Actual)	Hospital Acquired	Community Acquired	Projected MRSA Positive Blood Cultures
Apr-06	787	112	**3**	0	3	**4**	3	1	3
May-06	857	157	**6**	2	4	**8**	4	4	3
Jun-06	940	149	**4**	1	3	**6**	3	3	3
Jul-06	943	171	**3**	1	2	**2**	1	1	3
Aug-06	842	166	**9**	2	7	**4**	3	1	3
Sep-06	863	162	**3**	1	2	**5**	4	1	2
Oct-06	976	172	**7**	2	5	**1**	0	1	2
Nov-06	907	162	**6**	0	6	**5**	4	1	2
Dec-06	951	162	**5**	1	4	**5**	4	1	2
Jan-07	1038	202	**6**	3	3	**1**	1	0	2
Feb-07	938	170	**3**	0	3	**0**	0	0	2
Mar-07	920	155	**4**	1	3	**0**	0	0	2
Totals	**10962**	**1940**	**59**	**14**	**45**	**41**	**27**	**14**	**38**

Table 1: Illustration of total blood cultures processed within the microbiology laboratory, total amount which become positive and of those which were MSSA and MRSA positive broken down by hospital or community acquired and performance against agreed target for MRSA

Following root cause analysis of each bacteraemia, main sources for infection have been identified as the presence of indwelling peripheral IV line and pre-existing urinary tract infection, associated with indwelling urethral catheter. A peripheral line audit carried out on the Maidstone site in February identified key actions in association with the management of care of these lines, namely documentation of insertion dates. This has triggered actions to improve this documentation and management of indwelling devices in general in conjunction with a more extensive roll out of the Saving Lives Programme, in association with the Chief Nurse, which will audit care and management of indwelling devices by staff at ward and department level and enable them to learn from the audit findings and identify key areas for action.

The National and Local Picture for MRSA Bacteraemia

The table below illustrates the Trusts position compared nationally with regard to reporting of actual numbers for MRSA bacteraemia.

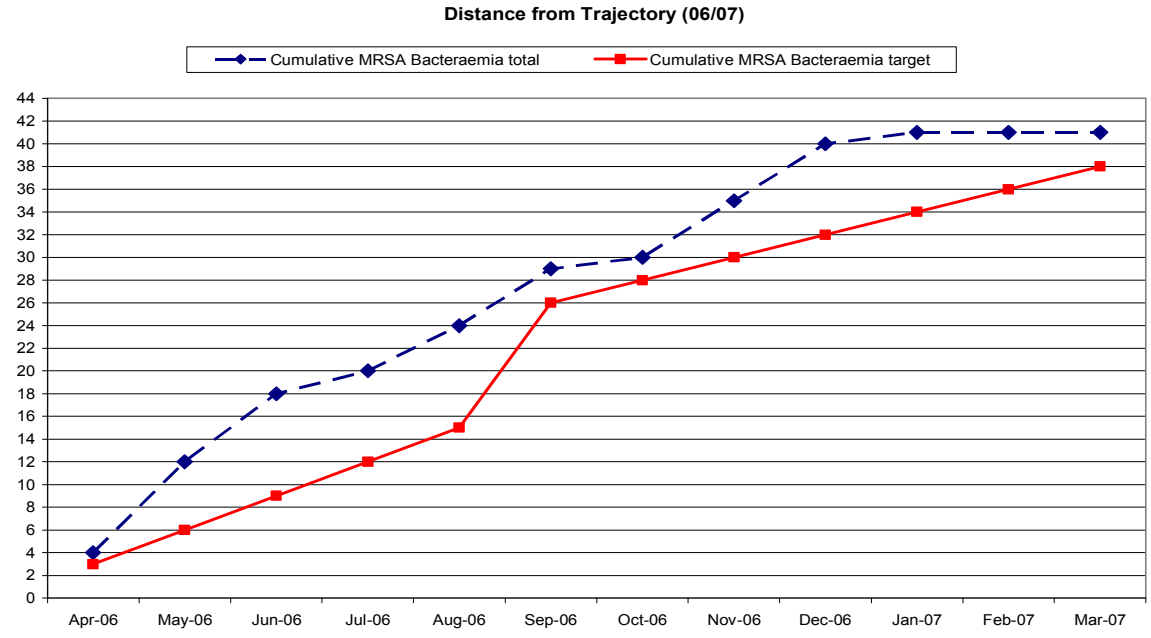
It can be seen that for quarters one and two 2006/07 the Trust was in the bottom third of Trusts reporting the highest actual number for MRSA bacteraemia. For quarter three, it can be seen that the Trust improved to be in the middle third.

	April-June 2006	July-September 2006	October-December 2006
Total Number of Trusts reporting	172	172	172
Trust position (from the highest number of reports)	32	54	63

Table 2: Illustration of Trust Performance compared with the National Picture for MRSA Bacteraemia Reports

The MRSA bacteraemia performance can then be illustrated, as below, as a year end performance against an agreed trajectory or target.

Figure 1: Trust Performance against MRSA Bacteraemia Target (1st April 2006 to 31st March 2007)



The target for 2007/2008 is 23 MRSA bacteraemias.

3.2 *Clostridium difficile*

Clostridium difficile in patients above 65 years of age is part of mandatory reporting to the Health Protection Agency. Internally we have monitored the total number of cases in all age groups for the past year. C. difficile may occur as sporadic cases, or as part of an outbreak. There are a number of predisposing factors for C. difficile infection including underlying conditions, antibiotic usage, age etc.

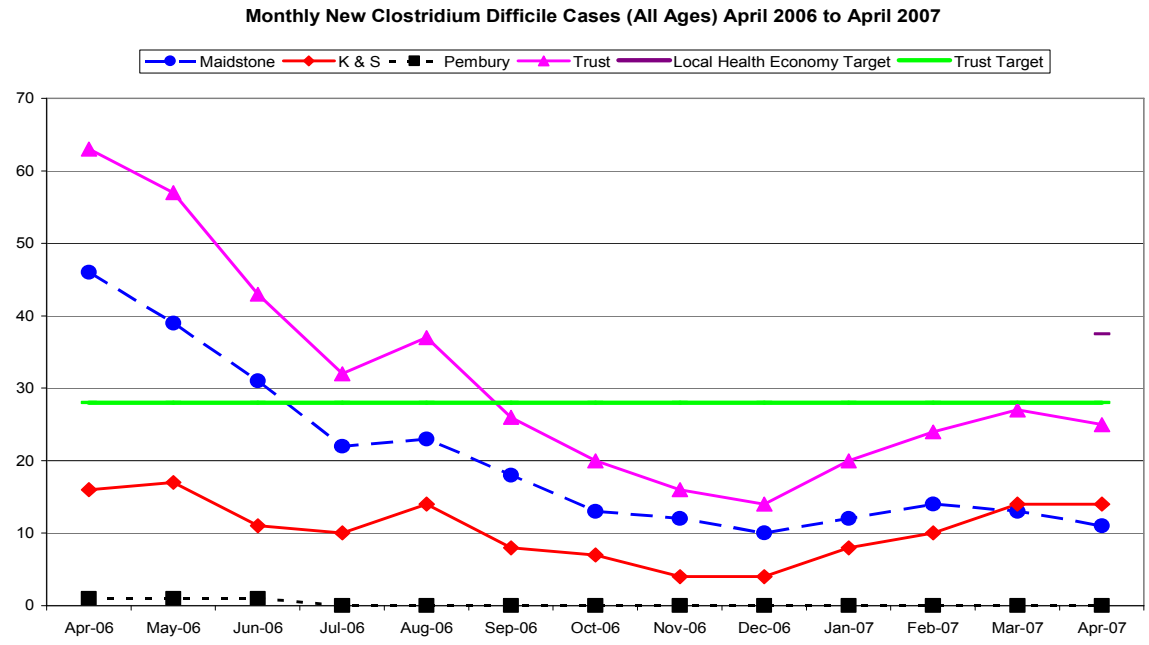
From 1st April 2007 the criteria for mandatory reporting of C. difficile is changing to encompass all positive results in patients above 2 years of age. The reporting will be through the web based system which is in existence for MRSA bacteraemias.

Along with this, Trusts now have to set locally agreed targets with the PCTs for C. difficile. The target we have within the SLA with WK PCT is 450 for the year. This equates to 37.5 per month for the Trust as a whole. We have our internally trigger threshold of 28 per month, divided across each site with a split of 20 at Maidstone and 8 at Kent & Sussex. This enables to ICT to have triggers for action arising from their monthly surveillance.

The graph below illustrates the outbreak of C. difficile that occurred from April 2006 and how the implementation of control measures has brought the incidence of new cases down throughout the year.

We have been experiencing a rise in incidence particularly on the Kent & Sussex site since January of this year, details of outbreaks associated with this rise are detailed later in this report.

Figure 2: Monthly new in hospital cases of *Clostridium difficile* (All ages) by site (1st April 2006 to 31st March 2007)



The National and Local Picture for *Clostridium difficile*

The table below illustrates the Trusts position compared nationally with regard to reporting of actual numbers for *Clostridium difficile* in patients >65 years of age.

It can be seen that for quarters one and two 2006/07 the Trust was in the bottom third of Trusts reporting the highest actual number for *Clostridium difficile* (improving from the bottom of the bottom third to the top of the bottom third from quarter one to quarter two). For quarter three, it can be seen that the Trust maintained in the middle third.

	April-June 2006	July-September 2006	October-December 2006
Total Number of Trusts reporting	172	172	172
Trust position (from the highest number of reports)	14	54	52

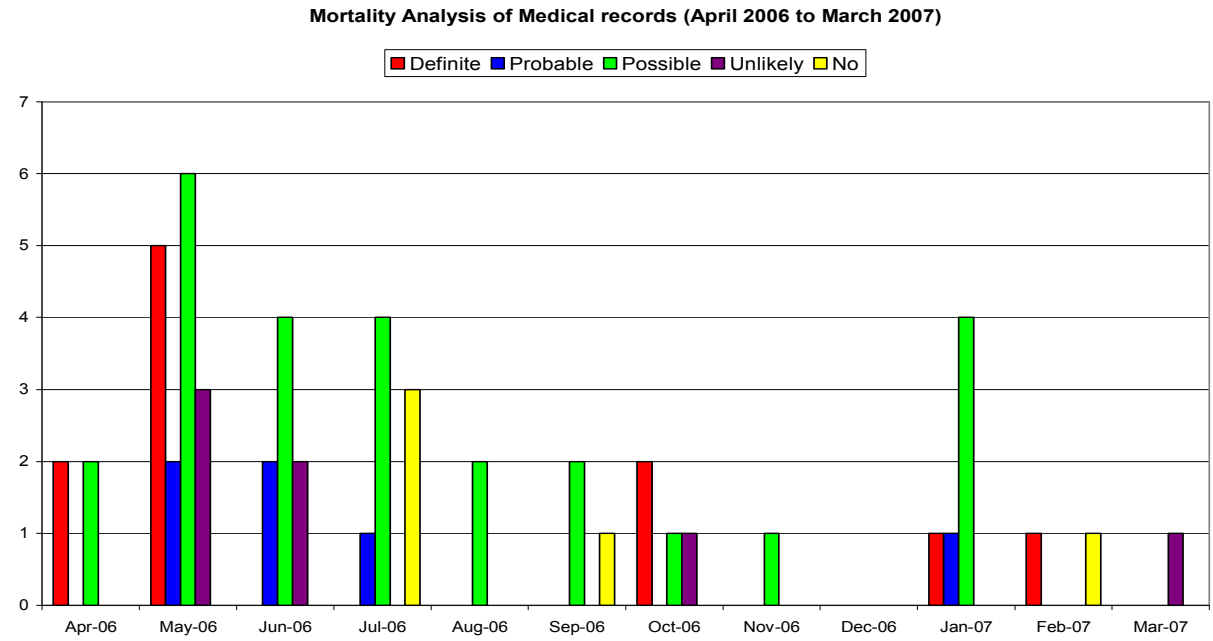
Table 3: Illustration of Trust Performance compared with the National Picture for *Clostridium difficile* Reports

3.3 Patients Who Have Had Clostridium Difficile and Have Died

As part of the ongoing reporting and review processes undertaken within the ICT, the collation of data pertaining to patients who have had C. difficile and have died continues. This commenced during the outbreak of 2006 and will be an ongoing part of the ICT activities.

The graph below illustrates data following mortality analysis of the medical records of those patients who have had C. difficile and have died and this is reported on the death certificate as either a main cause of death or contributory factor.

Figure 3: Mortality Analysis of Medical Records for Patients who have C. difficile and have died



This graph illustrates that there have been a further three patients whose death was either definitely or probably as a direct result of C. difficile for quarter 4 of 2006/07.

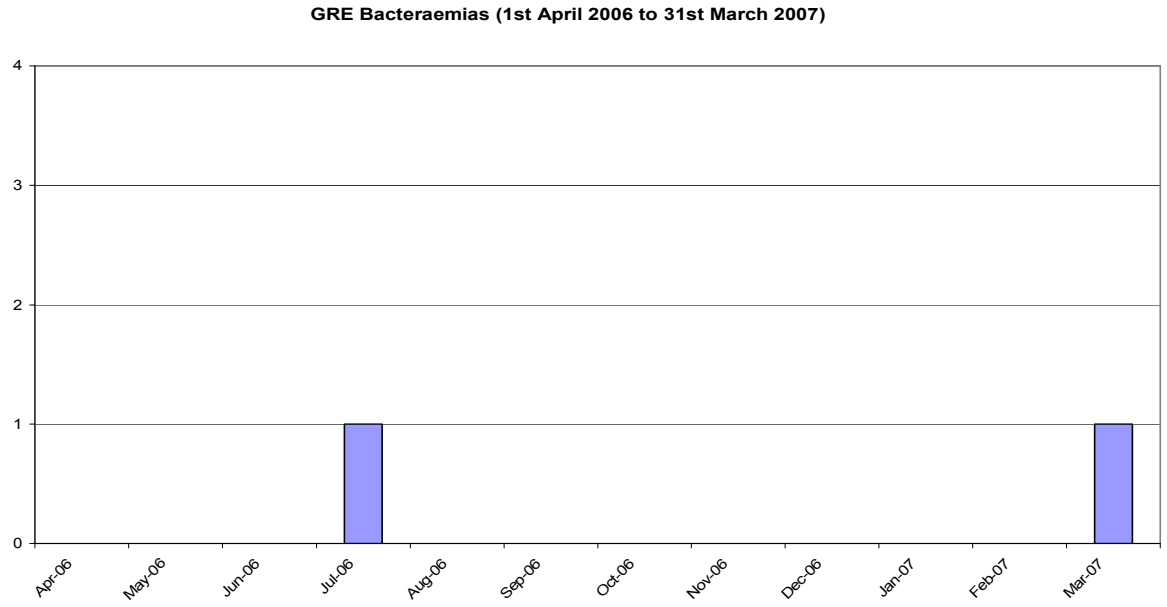
3.4 Glycopeptide-Resistant Enterococci (GRE) Bacteraemias

Enterococci are bacteria that are commonly found in the bowel of normal healthy individuals. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections.

The two most common species of Enterococci are *E. faecalis* and *E. faecium*. During the mid-1980s enterococci with resistance to glycopeptide antibiotics such as vancomycin and teicoplanin emerged, termed glycopeptide-resistant enterococci (GRE). Most GRE are *E. faecium*.

GRE surveillance has been mandatory since September 2003.

Figure 4: GRE bacteraemias from 1st April 2006 to 31st March 2007



Neither of these patients is thought to have acquired GRE as result of cross infection on hospital.

3.5 Mandatory Surgical Site Infection Surveillance

In *Getting Ahead of the Curve* the prevention of healthcare associated infection (HCAI) was highlighted as a priority for action by the Chief Medical Officer. A component of the strategy for action is surveillance, including surveillance of Surgical Site Infections (SSI). A sub-group of the Department of Health's Healthcare Associated Infection Surveillance Steering Group made recommendations for extending surveillance of SSI in orthopaedic surgery to all English Trusts, greater ownership of the surveillance by orthopaedic professionals and the development of systems to enable local data handling. Subsequently, surveillance of SSI in orthopaedic surgery became mandatory from April 2004.

Below are graphs illustrating the total number of operations for each of the procedures which are mandatory – knee replacement, hip replacement and hemi-arthroplasty, for each site (Kent & Sussex and Maidstone) followed by a graph for

each illustrating the infection rates for each for each site up to the quarter October to December 2006.

Although the Trust is up to date with this data collection and submission to the Health Protection Agency (HPA), there is always a time lag in the reports returning from the HPA following their analysis as they need to wait for data from all hospitals taking part in order to put the figures of all hospitals in the reports.

Following the data below for Oct-Dec 2006 is the raw data collated internally for Jan-Mar 2007. It needs to be borne in mind that this is raw data and may be altered once analysed by the HPA and will not put local data in perspective to all hospitals.

Figure 5: Total knee replacement operations and associated infections Jan 2005-Dec 2006

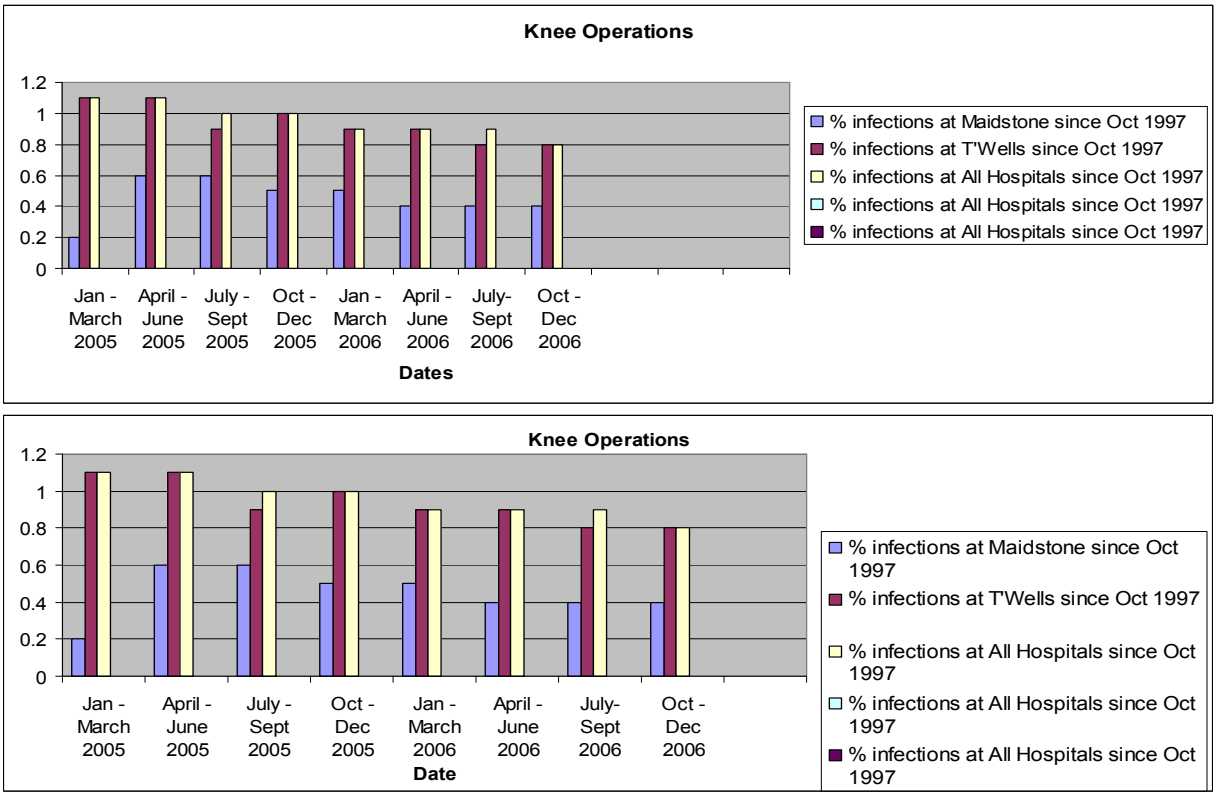
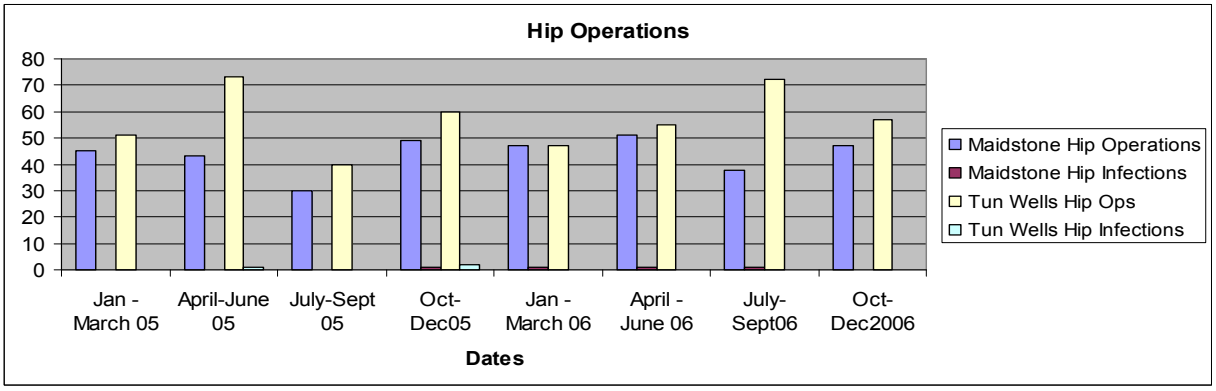


Figure 6: Total hip replacement operations and associated infections Jan 2005-Dec 2006



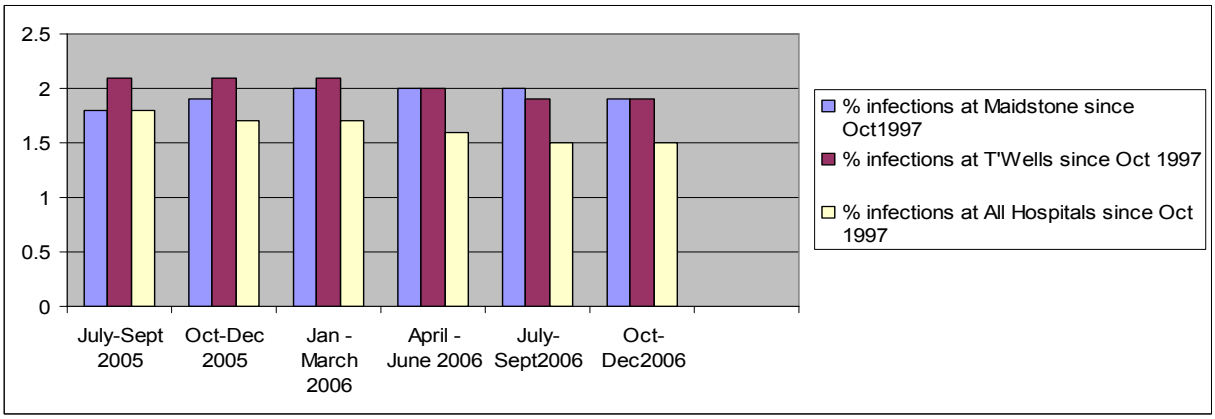
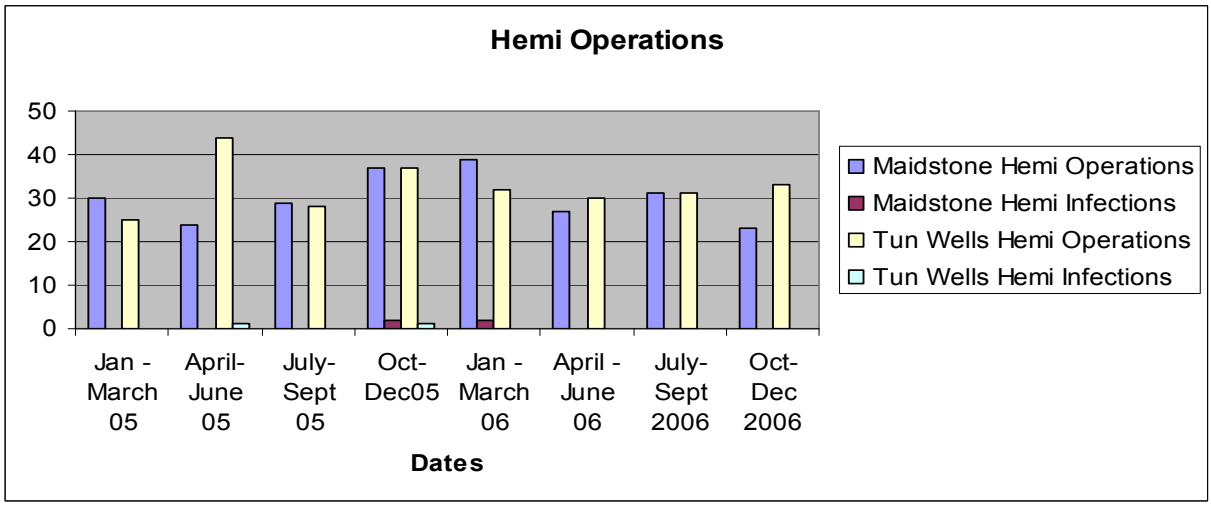


Figure 7: Total hemiarthroplasty operations and associated infections Jan 2005 to Dec 2006



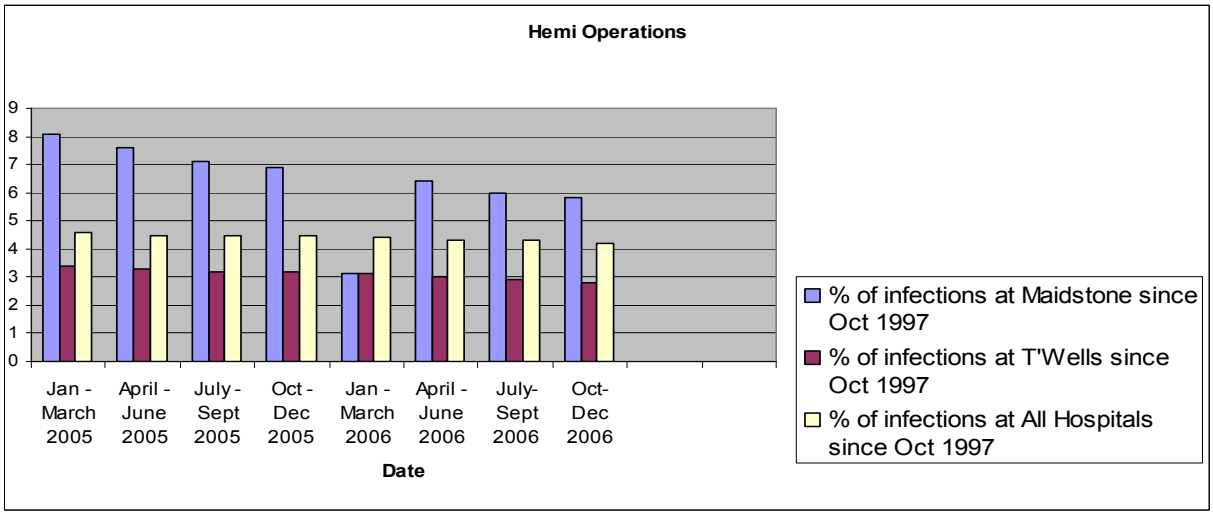


Table 4: Raw data Collected Internally January to March 2007

	Kent & Sussex	Maidstone
Hip Operations Performed	55	34
Surgical Site Infections	1	1
Knee Operations performed	52	55
Surgical Site Infections	1	0
Hemiarthroplasty Operations Performed	43	19
Surgical Site Infections	3	1

3.6 MRSA Acquisition Data

In addition to Mandatory surveillance the Infection Control Team also collate data relating to new MRSA acquisitions (both infections and colonisations), other than bacteraemias as illustrated in the graphs below.

There will shortly be a revised MRSA guidelines document to be issued from the Infection Control Team which recommends increased screening in line with national Guidelines. The new acquisition line as illustrated below will start to rise as a result of this as the more screening carried, the more new cases will be found. This will enable us to know our population and the carriage rate of MRSA and plan for appropriate placement and procedures accordingly, thereby reducing the risk of cross infection from the unknown carrier.

Figure 8: Illustration of MRSA positive results (new and previously known cases)

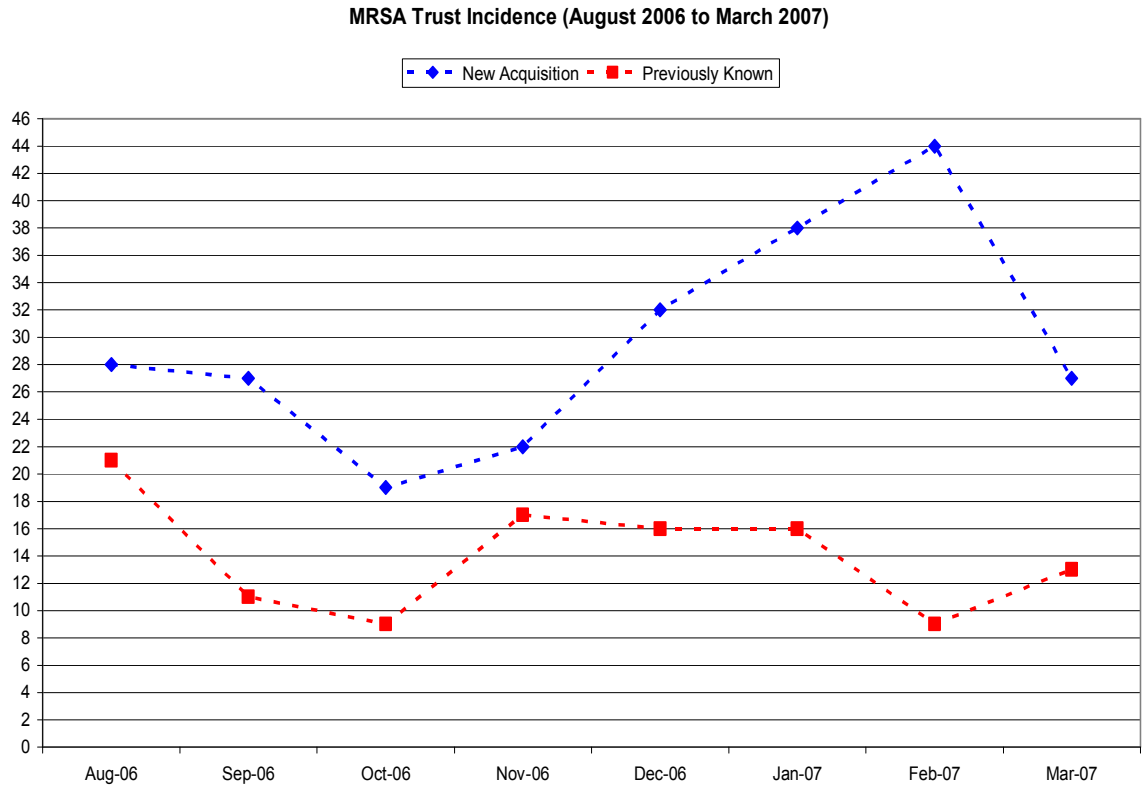
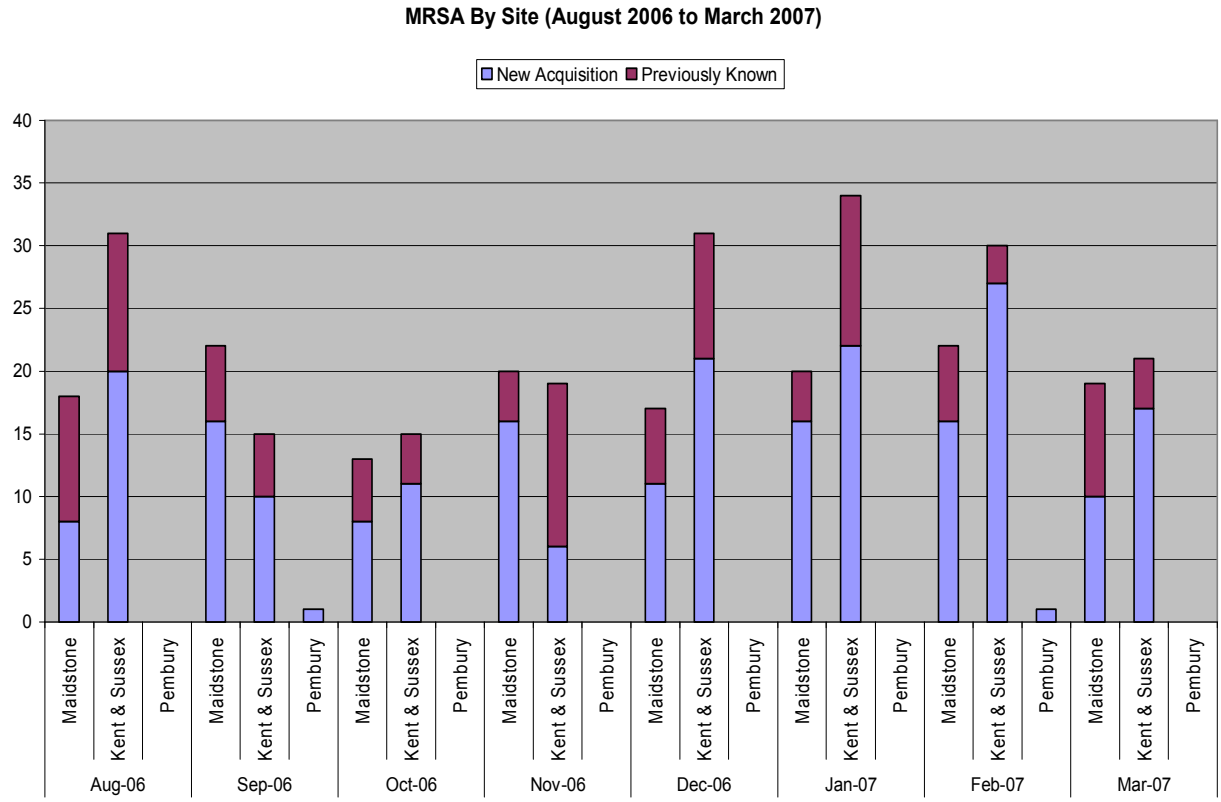


Figure 9: Illustration of MRSA positive results (new and previously known cases) by site



4.0 Outbreaks

Table 5: Summary of Reported Outbreaks of Infection 1st January 2007 to 31st March 2007

Date of outbreak	Type of outbreak	Number of patients involved	Number of wards	Number of staff affected	Actions	Wards closed	Number of beds lost	Date outbreak declared over
30th January 2007	CDT (K&S)	**11** (plus 4 identified as false positives due to a lab. error 3 - Ward 10 1 – ICU)	**8** Ward 10 = 3 (1 via GP post discharge) Ward 5 = 1 Ward 8 = 1 Ward 12 = 1 Ward 14a =1 (via GP post discharge) Ward 11a = 3 (2 via GP post discharge) Ward 9 = 1	**None**	**1**. • Outbreak declared • SUI declared • Reported to HPU **2.** Cases identified, isolated with dedicated toilet facilities and barrier nursed **3**. Stool charts implemented **4.** Patients prescribed the necessary systemic treatment, antibiotic review **5.** Patient / visitor information given **6.** Daily out break meeting held **7.** Enhanced cleaning with Actichlor plus **8.** Increase in cleaning personnel **9.** Implementation of daily diarrhoea assessment form **10**. Restricted visiting	**None**	None as all patients accommodated in single rooms	**9th February 2007**

15th February 2007	Norovirus (K&S)	**28**	**3** wards involved • Ward 11a • Ward 3 • Ward 5	**8**	**Ward 11a:** • Two patients identified with Norovirus: one was discharged the other transferred to ward 3 • Eleven beds were closed for 24 hours. The ward was terminally cleaned and re-opened. **Wards 3 & 5:** **1**. Outbreak declared. **2**. Daily out break meetings and reports **3.** Implementation of daily diarrhoea assessment form **4.** Enhanced cleaning with Actichlor plus **5.** Increase in cleaning personnel **6.** Patient /visitor and staff information provided on Norovirus. **7.** Use of ward closure posters. **8**. Restricted visiting	**3** • Ward 11a for 24 hours • Ward 3 for the duration of the outbreak • Ward 5 closed for 5 days	**17**	**2nd March 2007**
9th March 2007	Norovirus (K&S)	**13**	**1** Ward 3	**2**	**1**. Minor outbreak declared **2.** Daily monitoring with daily reports **3.** Use of strict universal precautions **4.** Enhanced cleaning with Actichlor plus **5**. Patient / visitor and staff	**1**	**6**	**21st March 2007**

					information provided on Norovirus. **6**. Restricted visiting **7.** Use of ward closure posters.			
24th March 2007	Norovirus (Maidstone)	**127** (+3)	**14** Primary wards affected with highest incidence : Cornwallis : 26 John Day ; 21 Jonathan Saunders : 14 Foster Clark : 15 Whatman : 13 Boxley : 10	**28** staff directly related to affected wards **Plus : 29** other staff reported from other areas of hospital	**1**. • Major outbreak declared • SUI declared • Reported to HPU **2.** Daily assessment and advice by IC team issued on management **2.** Implementation of daily diarrhoea assessment form **3.** Daily out break meetings - Commenced 26/03/07 **4.** Trust wide daily Outbreak Summaries issued from 26/03/07 **5.** Enhanced cleaning with Actichlor plus **7.** Night time cleaners used for terminal cleans and increased cleaning of affected wards toilets/ sluice rooms overnight help **8.** Rationalization of domestic and tea ladies movements **9**. Restricted visiting **10**.Patient /visitor and staff information provided on Norovirus. **11.** Use of ward closure posters	**Cornwallis** 24/03/07 - 07/04/07 Bay A remained closed till 14/04/07 **John Day** 26/03/07 – 09/04/07 **Boxley** Bay A 25/03/07 – 29/03/07 Bay B 31/03/07— 7/04/07 Bay C 09/04/07- 10/04/07 Bay B 09/04/07- 14/04/07 **Culpepper**	**114** **61** **21** **12**	**13th April 2007**

					13. HCC notification of outbreak **14.** External communication – radio and local newspaper **15.** Extraordinary meeting of Kent Wide ICC **16.** Close liaison with bed management	Bay C 25/03/07 Whole ward closed 28/03/07 -01/04/07 **Jonathan Saunders** Bays A+B 27/03/07 Bay A re-opened 07/04/07 Bay B re-opened 12/04/07 **Pye Oliver** Bay B 29/03/07 Whole ward closed 31/03/07 re-opened 03/04/07 **Whatman** BaysB+D 29/03/07 Whole ward closed 03/04/07 Bay B reopened 06/04/07 Bay C+D re-	**31** **40** **18** **39**	

						opened 08/04/07 Bay A re-opened 14/04/07 **Foster Clark** Bay –B closed 29/03/07 Whole ward closed 31/03/07 Bay B-re-opened 06/04/07 Bay C=D re-opened 09/04/07 Bay A re-opened 13/04/07 **Mercer Ward** Bay A+D closed 03/04/07-09/04/07 Bay A closed 10/04/07-11/04/07 **Whitehead**	**17** **6**	

						Bay A closed 03/04/07-11/04/07		
31st March 2007	CDT (Maidstone)	**4** patients identified between 27/03/07-02/04/07	**1** Foster clark	None	1. SUI declared 2. Isolation / cohorting of CDT positive patients to Bay B and later into Side Rooms 3. Designated staff following strict isolation/ barrier nursing precautions cared for CDT positive patients. 4. Disinfection cleaning throughout whole ward with particular attention to affected bay/ sluice room/ toilets 5. Information on CDT given to both patient relatives and visitors. 6. Review of antibiotic history of CDT positive patients 7. Ribotyping of specimens – revealed all 4 samples to be type 106. 8. Review of environmental cleanliness of ward 9. Close liaison with bed management	In midst of Norovirus outbreak 24/03/07-13/04/07	Beds lost part of the above figure during that period	**07th April, 2007**

5. Other Infection Control Team Activities

5.1 The Health Act 2006

The Health Act 2006, which introduces a code of conduct for minimising the risk of healthcare associated infection, came into force with effect from 2nd October 2006. A gap analysis has been fully undertaken which was presented to the Trust Board earlier this year and an action plan has been compiled to ensure that the Trust is fully compliant.

5.2 Commodes

An audit of commode chairs was carried out across both sites in September for K&S and November 2006 for Maidstone. A large numbers of commodes had physical faecal staining and a number had to be condemned. Those that were identified as needing to be condemned were all replaced. Following this audit there was an intensive awareness raising campaign regarding decontamination.

The audit is to be repeated on 24th and 25th May for both sites.

5.3 Macerator Installation

There is a programme of replacing bed pan washers with macerators on the Kent & Sussex and Pembury sites which is well underway. There is also a programme to replace a numbers of macerators on all sites which are in need of replacement which is happening along side the bed pan replacement programme. The ICT have been involved in each stage of the planning for this programme to ensure all infection control considerations are risk assessed and managed. All areas needing macerator installation to replace bed pan washers are using maceratable bed pans and urinals and disposing of them as clinical waste in the interim.

5.4 Bed Reduction Programme (K&S)

All beds identified for removal from the balcony end of the wards have now been removed. There is to be a programme of work commencing after the macerator installation programme to install hand wash basins to that end of the ward and to reconfigure the curtain tracking to accommodate the bed reduction. Ward 14a is to be used as a decant area for patients whilst work is carried out on each ward.

6. Recommendation

Board is asked to note this report.

APPENDIX L

Infection Control Progress within Maidstone & Tunbridge Wells NHS Trust

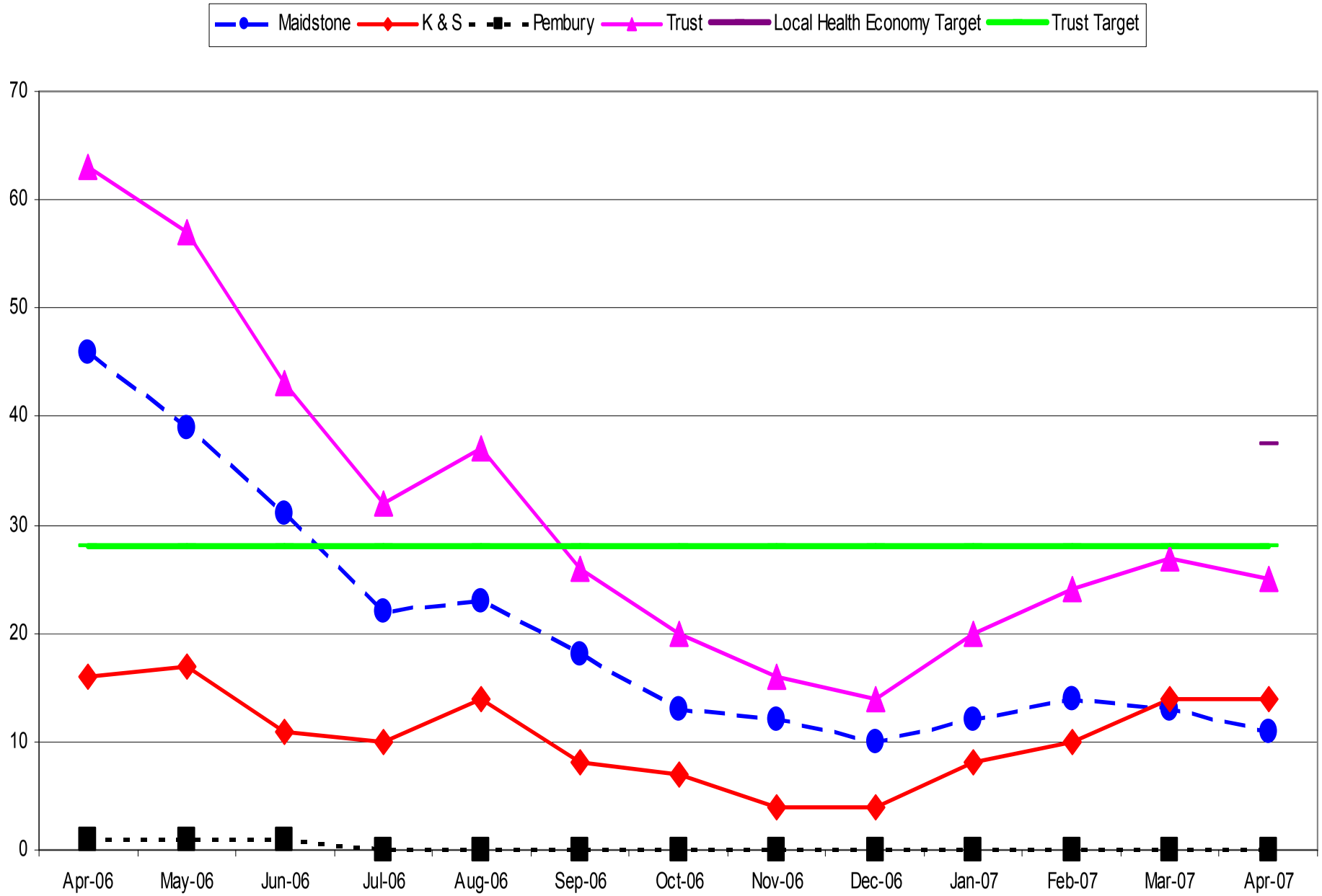
Gail Locock

Acting Director for Infection Prevention and Control

Outline of Presentation

- *Clostridium difficile* statistics
- MRSA Bacteraemia statistics
- Saving Lives Programme
- Clean Your Hands Campaign
- The Role of the Infection Control Link Nurse

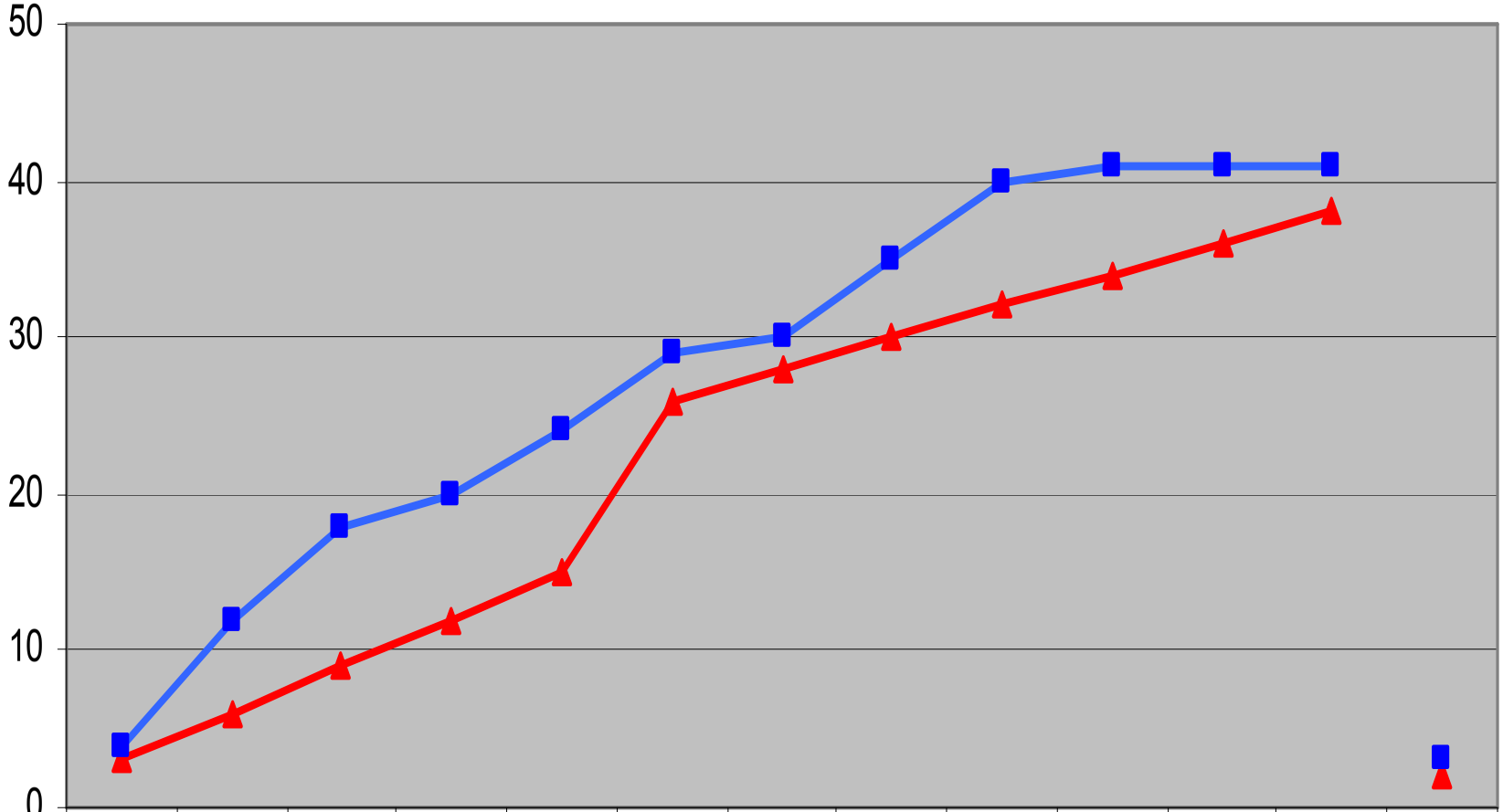
Monthly New Clostridium Difficile Cases (All Ages) April 2006 to April 2007



MRSA Bacteraemia vs Projected Rates (06/07)

	Total Blood Cultures Processed	Total Positive Blood Cultures (All organisms)	Total MRSA Positive Blood Cultures	Hospital Acquired	Community Acquired	Projected MRSA Positive Blood Cultures
Apr	787	112	4	3	1	3
May	857	157	8	4	4	3
June	940	149	6	3	3	3
July	943	171	2	1	1	3
Aug	842	166	4	3	1	3
Sep	863	162	5	4	1	2
Oct	976	172	1	0	1	2
Nov	907	162	5	4	1	2
Dec	951	162	5	4	1	2
Jan	1038	202	1	1	0	2
Feb	938	170	0	0	0	2
Mar	920	155	0	0	0	2
Totals	10962	1940	41	27	14	38

MRSA Bacteraemias - Cumulative 2006/07 and 2007/08



	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07
Cum. Target	3	6	9	12	15	26	28	30	32	34	36	38	2
Cum. MRSA	4	12	18	20	24	29	30	35	40	41	41	41	3

Saving Lives
'A Delivery Programme to Reduce Healthcare Associated Infections, including MRSA'

Self Assessment:
"Balanced Score Card"

High Impact Interventions:

No 1. Preventing the risk of microbial contamination
No 2. Central venous catheter care
No 2b. Peripheral line care
No 2c. Renal dialysis bundle
No 3. Preventing surgical site infection
No 4. Care of ventilated patients
No 5. Urinary catheter care
No 6. Reducing the risk of infection from and the presence of *Clostridium difficile*

Clean Your Hands Campaign

- Instigation of Clinical Champions
- Increasing awareness with all staff and the general public
- Hand hygiene audits (observational and facilities) undertaken at ward level
- Floor and wall signage
- Use of light box for technique training
- Increased resources to improve facilities
- Will review Hand Hygiene Leaflet


STOP
CLEAN
YOUR HANDS


ATTENTION
Visitors
Please disinfect your hands prior to entering and before leaving this ward/department.
HELP US TO PREVENT INFECTIONS.
Pour Softalind® into the hollow of your dry hands.
Use the simple 6 step routine to rub the product thoroughly around your hands and wrists for 30 seconds.
Please supervise your children.
Softalind
B|BRAUN
B|BRAUN
SHARING EXPERTISE
CLEAN
YOUR HANDS


Staff Office
ATTENTION
Visitors
Please disinfect your hands prior to entering and before leaving this ward/department.
HELP US TO PREVENT INFECTIONS.
Pour Softalind® into the hollow of your dry hands.
Use the simple 6 step routine to rub the product thoroughly around your hands and wrists for 30 seconds.
Please supervise your children.
B|BRAUN

Improving Link Nurse Role

- Joined up working
- Increasing their contribution
- Training
- Auditing
- Cascade information
- Two-way process

Thank You for Listening

Infection Prevention and Control

Dartford and Gravesham NHS
NHS Trust

"There remains the question whether at some future date the control of hospital cross-infection will have reached such a level of effectiveness that there will no longer be a place for an Infection Control Sister in General hospitals.

A similar argument that bacteriologists would become unnecessary in hospitals because of the advent of antibiotics was a familiar one about 1945 but is rarely heard today.

The future of hospital cross-infection is impossible to predict, but its present toll of misery is such that it would seem wiser to contemplate any measure that might reduce its incidence than to worry unduly about the possibility of an unemployed ICS at some future time."

Moore. B. Control of Infection (1961)

The *employment of a Senior Member of the Nursing Staff as a member of the Infection Control Team in General Hospitals*.

45 years later

'Hospital superbug' MRSA spreads to animal

THE SUN, Tuesday, January 11, 2005

CLEANERS' PAY CUT OVER DIRTY WARDS

Head matron's war on MRSA

HOSPITAL cleaning firms who leave wards dirty will lose PAY, the Government's head matron said yesterday.

Christine Beasley revealed a crackdown as the number of cleaners has halved in the past 20 years – while deaths from superbug MRSA have doubled. Health Secretary John Reid admitted the figures

By JANE SYMONS, Deputy Health Editor

SUPERBUGS KILL 20,000 A YEAR

NURS GAVE OUR NEW BABY MRS

Daily Mail, Thursday, January 27, 2005

Shock as health chiefs rule bouquets at the bedside are unhygienic

Hospital bans visitors from turning up with flowers

AMBULANCES SPREAD MRSA

Bugs found in every vehicle we tested

KILLER ON WARDS: KNOT ON!

Doctors are told to keep their ties tucked away to beat deadly MRSA bug

By Mike Merritt And Himaya Quasem

DOCTORS are being ordered to tuck in their ties to stop the spread of killer MRSA.

DIRTY DOCS

Hospital medics carry killer bug in neck-ties

Doctors' neck-ties have been revealed as a key source of the superbugs killing patients in Scots hospitals.

Infected ties are carrying MRSA (Methicillin Resistant Staphylo-Aureus) and other potentially fatal bugs from patient to patient.

Alarming research identifying ties as a prime source of infection yesterday prompted calls for ward doctors to ditch their neckwear.

Dr Nigel Cumberland, consultant microbiologist at Frimley Park Hospital, Sussex, is one of the authors of the report published by the Royal College of Surgeons in England.

He said: "The tie is a decorative but functionless item of clothing, worn by most male doctors.

'Clean yourself' advice on MRSA

Patients should bring their own medical wipes and scrub up before coming to hospital to cut MRSA, say advisors.

They should ask relatives to launder their clothes and make sure their visitors have washed themselves properly before entering th ward.

The Patients Association's 10-point code also advises patients to collect their own rubbish and insist staff wash their hands to cut infection risk.

Nurses welcomed most of the measures but questioned their practicality.

Patients' cleanliness code

- Wash before coming to hospital
- Ask relatives to launder nightwear/bring toiletry supplies
- Visitors should be freshly showered/bathed
- Only two visitors at a time
- Visitors should not sit on the bed
- Patients in isolation should not have visitors
- Ask staff/visitors to wash their hands
- Bring medical wipes with you and clean your hands after using a bottle or bed pan
- Collect your own bedside rubbish
- Fill out hospital questionnaires

We

Hospitals draw up new MRSA rules

Two north London hospitals have drawn up strict new hygiene guidelines to combat the spread of the hospital superbug MRSA.

Nurses uniforms at North Middlesex and Chase Farm hospital, both in Enfield, will be laundered on site and ties and wrist watches will banned.

Both hospitals have high rates of the bacteria-busting bug.

NEW NHS SUPERBUG IS WORSE THAN MRSA

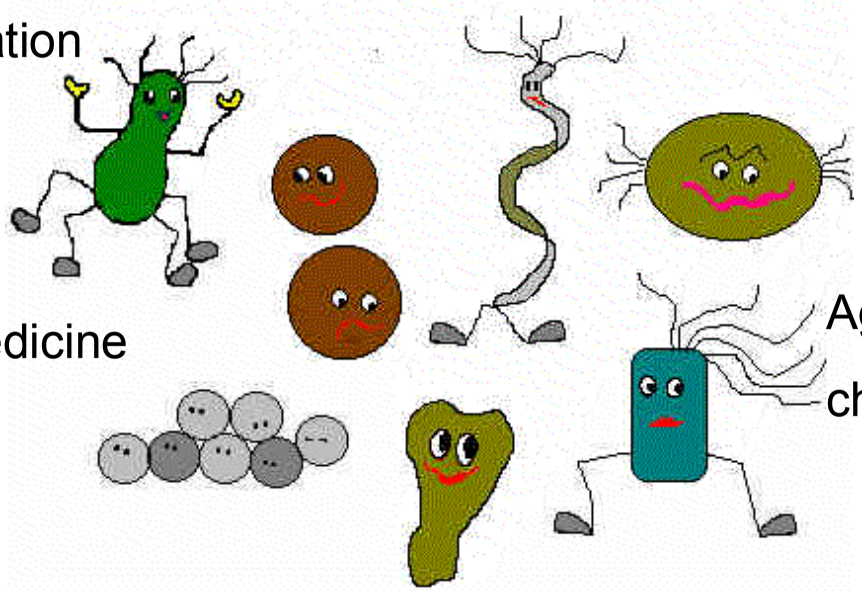
12 KILLED BY A NEW HOSPITAL SUPERBUG

12 DIE IN JUST ONE NHS HOSPITAL

The deadly new bug stalking our wards

Targets

Public/Patient Expectation



Use of Antibiotics

Advances in Medicine

Aging Population/

chronic conditions

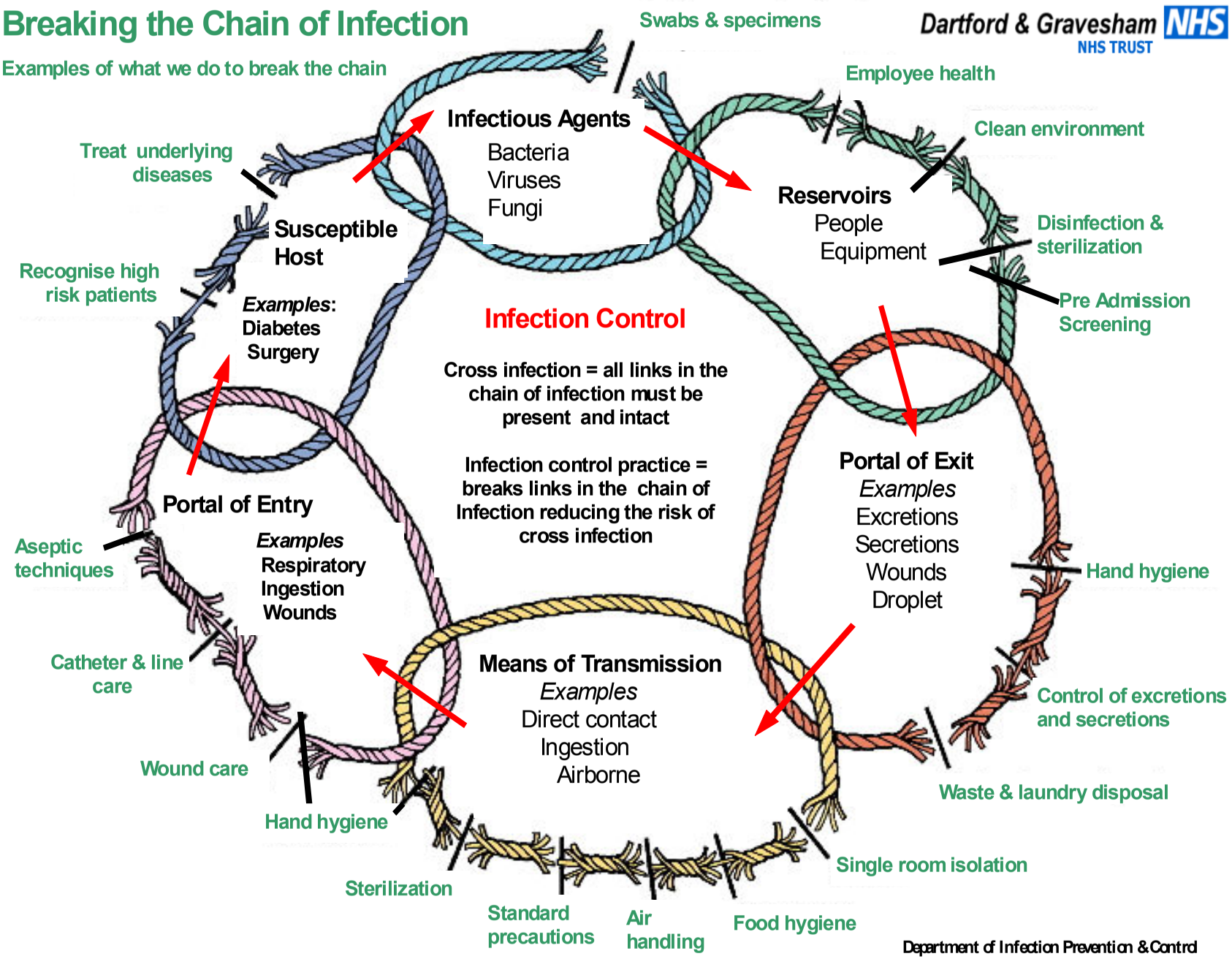
Re-emerging Diseases

(TB, Influenza)

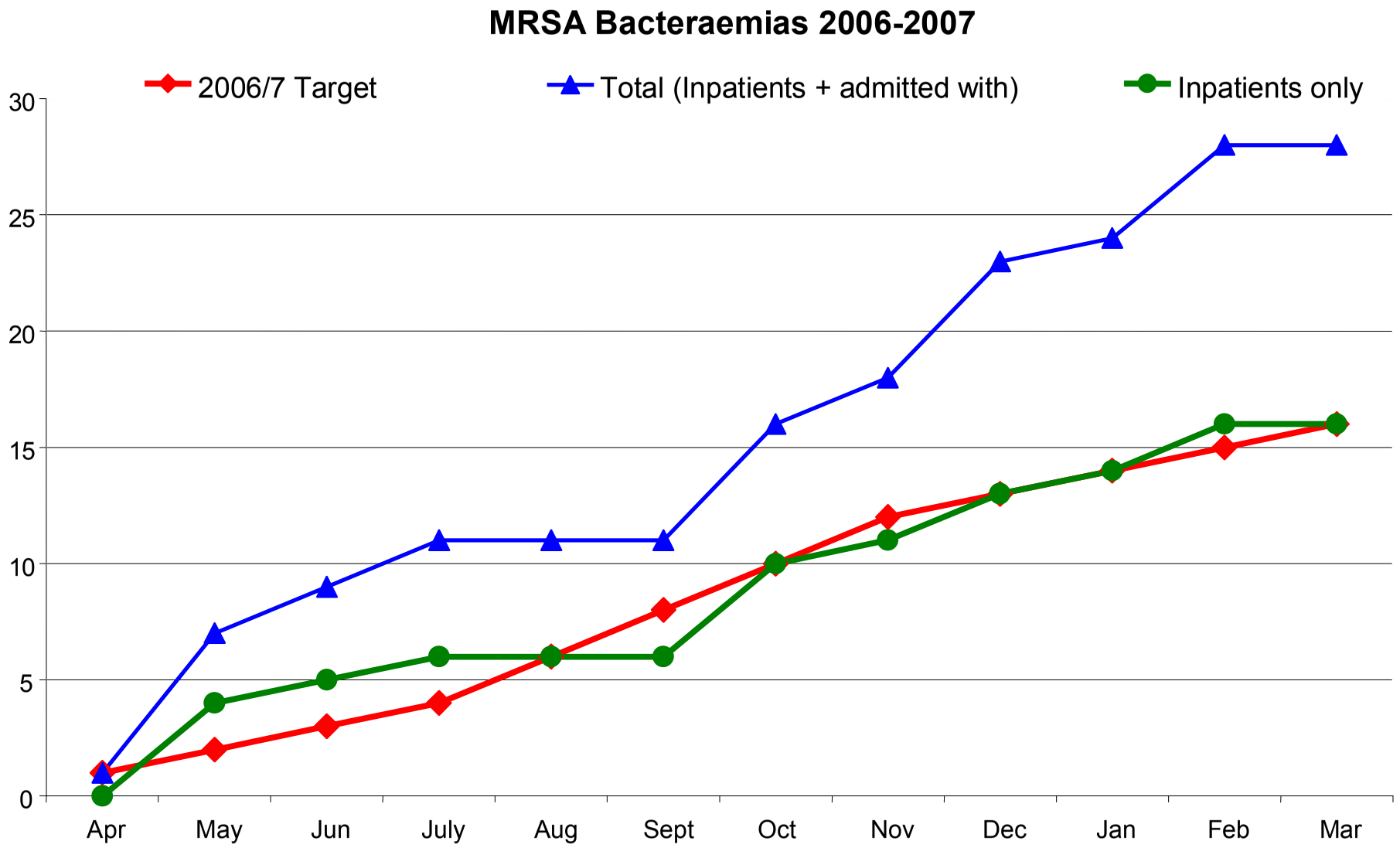
Breaking the Chain of Infection

Examples of what we do to break the chain

Dartford & Gravesham NHS NHS TRUST



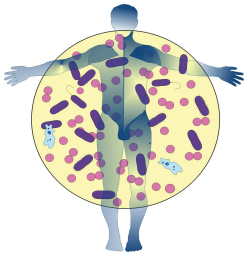
Department of Infection Prevention & Control

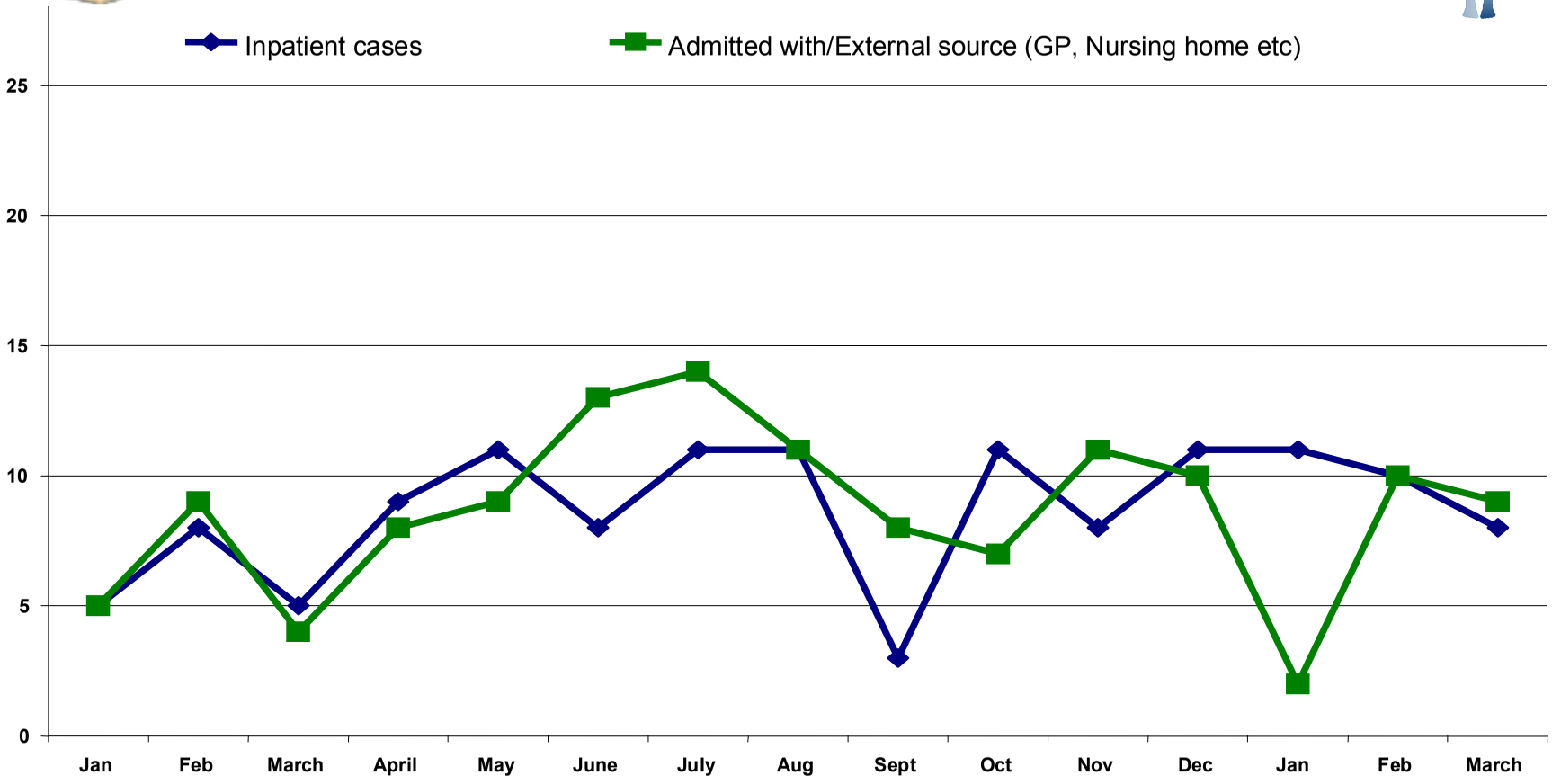

MRSA Bacteraemias 2006-2007
2006/7 Target
Total (Inpatients + admitted with)
Inpatients only
30
25
20
15
10
5
0
Apr
May
Jun
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar

Clostridium difficile cases >65's

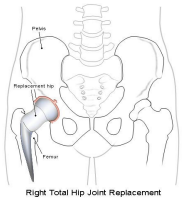
(Positive Laboratory Specimens)

January 2006 - March 2007





Notes: We have not had any identified cases of type 027 (Hypervirulent strain of Clostridium difficile)
From April 2007 we will be reporting all positive laboratory specimens irrespective of age 2

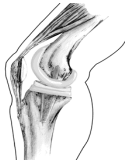


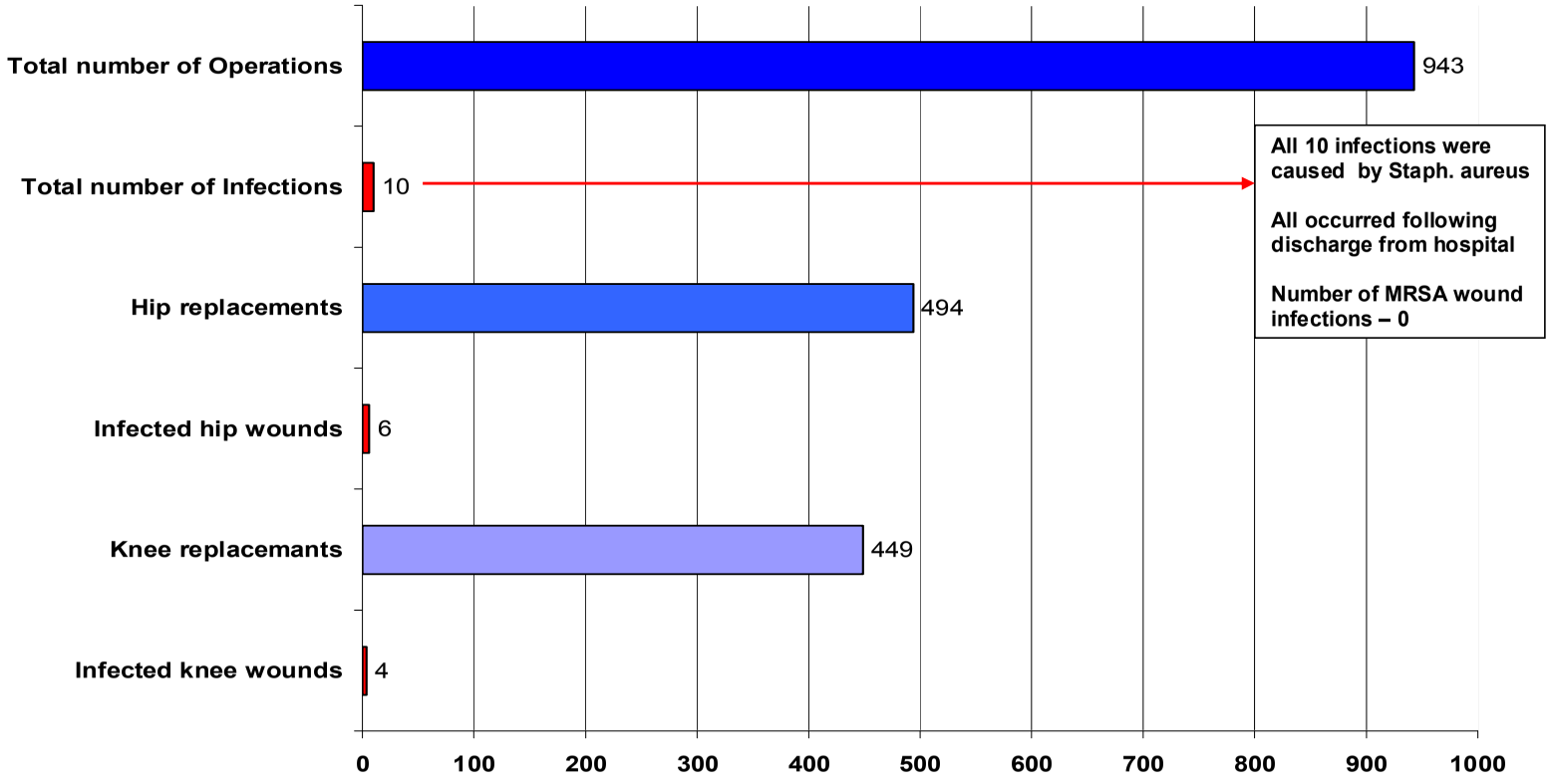
Right Total Hip Joint Replacement

Post Operative Wound Infections

Elective Hip & Knee Replacements
April 2004 – December 2006

Results of surveillance undertaken from admission until discharge from ward / bridging team

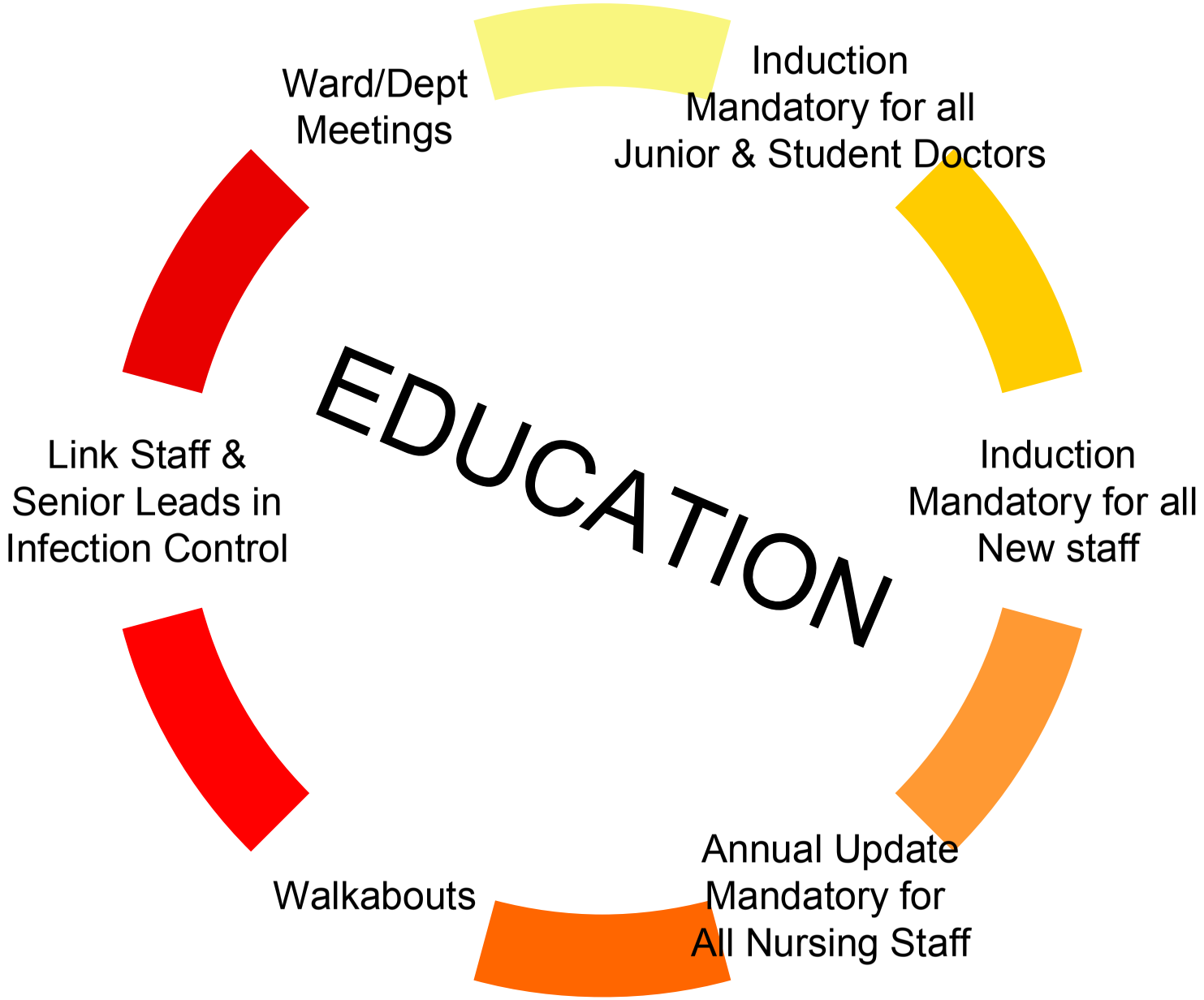




Results of the Third Prevalence Survey of Healthcare Associated Infections in Acute Hospitals 2006
Published February 2007

Prevalence Rate	National	Darent Valley Hospital
	8.19%	5.2%

Infection type	National Rate	Darent Valley Hospital Rate
MRSA	1.28%	0.3%
Clostridium difficile	1.98%	1.5%
Norovirus	0.74%	0.0%
Surgical site	1.27%	0.9%
Urinary tract	1.80%	0.6%
Pneumonia	1.27%	1.8%
Gastrointestinal	2.02%	0.9%
Lower respiratory tract	0.55%	0.6%
Primary bloodstream	0.62%	0.3%


EDUCATION
Induction
Mandatory for all
Junior & Student Doctors
Induction
Mandatory for all
New staff
Annual Update
Mandatory for
All Nursing Staff
Walkabouts
Link Staff &
Senior Leads in
Infection Control
Ward/Dept
Meetings

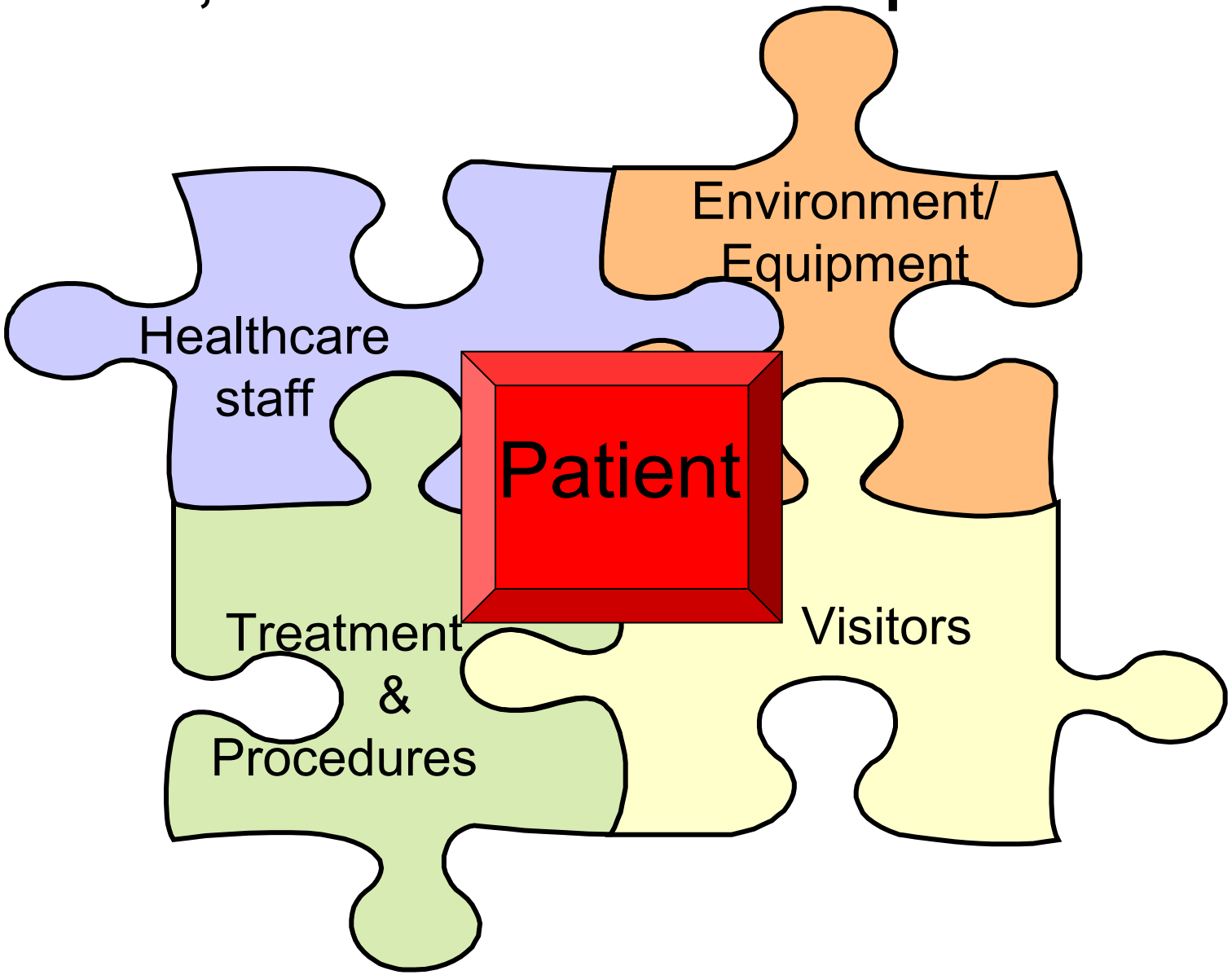
What are we doing about MRSA and other infections?

Hand hygiene (Staff, Patients and Visitors)

Clean environment & equipment

Prudent use of antibiotics

Working as a TEAM to provide a safe, clean environment for patients



East Kent NHS Trust
Infection Control

end of year report
April - 2006-07

James Nash
Director Infection Prevention and Control
Sue Roberts
Deputy Director Infection Prevention Control

Topics for discussion

- Restructuring Infection Control
- Clostridium difficile
- MRSA bacteraemia (DH targets)

Clostridium difficile

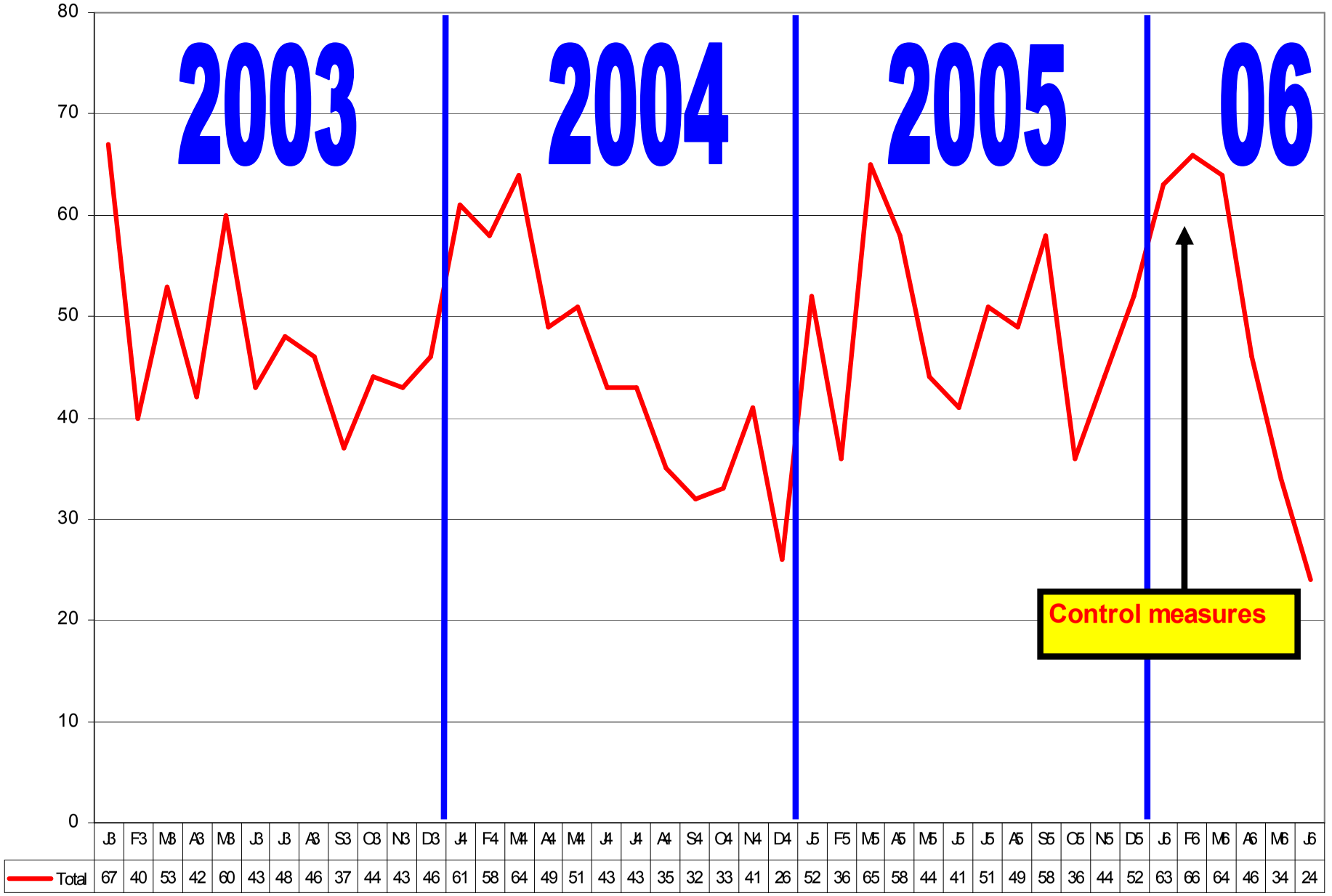
- Important cause of diarrhoea and colitis
- Mainly in patients receiving antibiotic therapy

- Elderly hospital patients vulnerable
- The new hypervirulent strain (O27)

Clostridium difficile
EKHT Annual report of 2005-06

- Increased rate of C difficile Jan-Feb 2006
- O27 strain reported locally
- New infection control measures required
- Objectives for 06-07
  - Establish control over prescribing
  - Reduce rates of C difficile to < 15 cases/month/site

East Kent C difficile monthly totals Jan 2003-June 2006

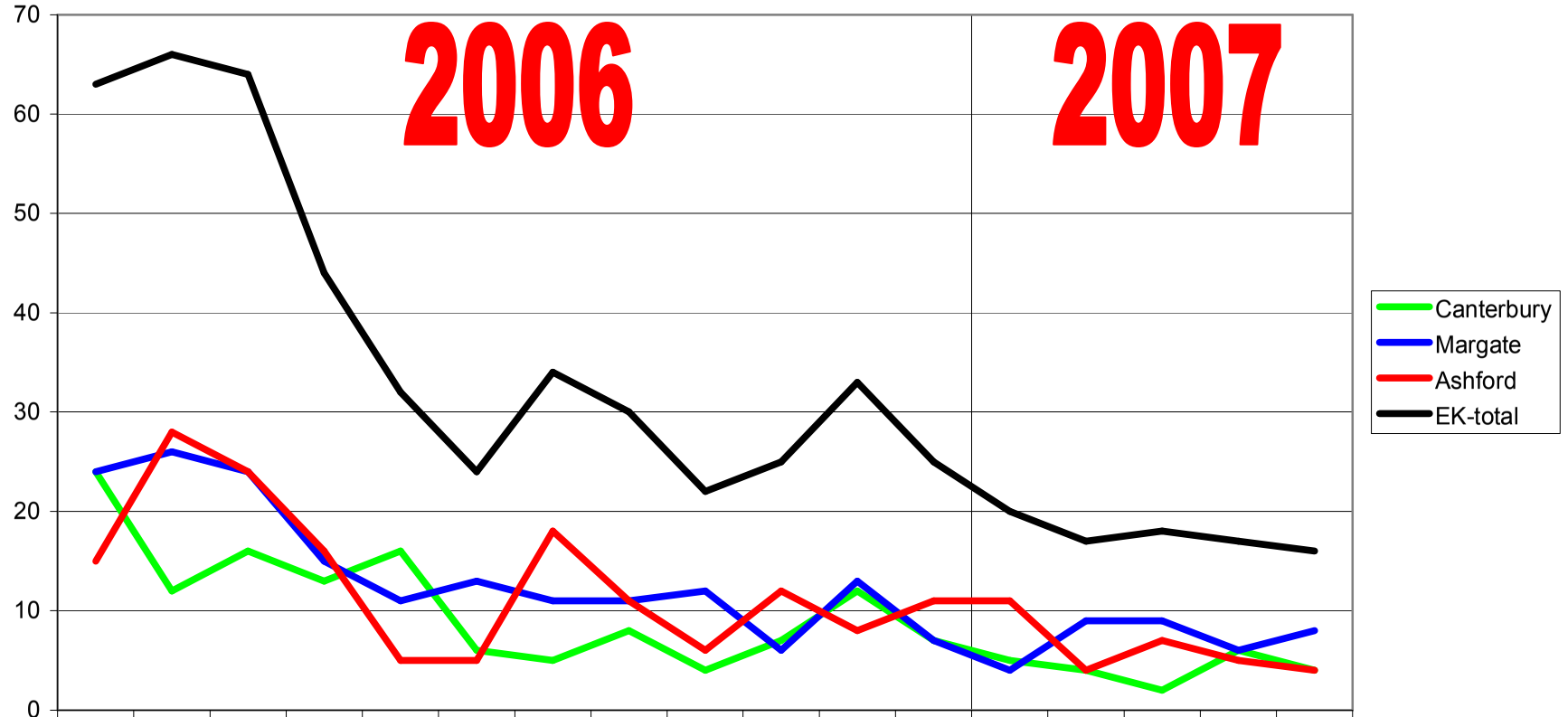


	J3	F3	M3	A3	M3	J3	J3	A3	S3	O3	N3	D3	J4	F4	M4	A4	M4	J4	J4	A4	S4	O4	N4	D4	J5	F5	M5	A5	M5	J5	J5	A5	S5	O5	N5	D5	J6	F6	M6	A6	M6	J6
Total	67	40	53	42	60	43	48	46	37	44	43	46	61	58	64	49	51	43	43	35	32	33	41	26	52	36	65	58	44	41	51	49	58	36	44	52	63	66	64	46	34	24

Sustained fall in 2007:

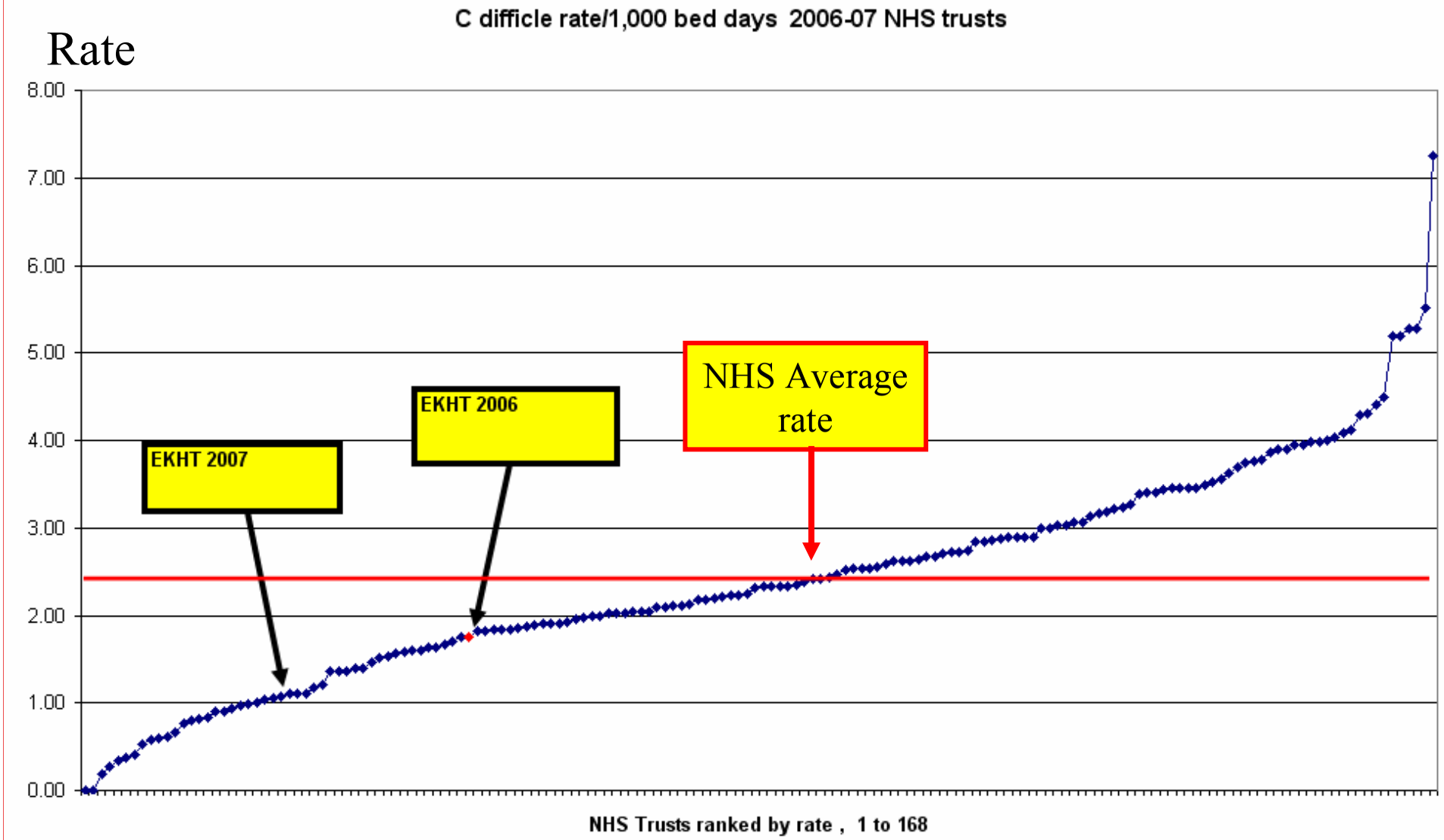
C difficile rate < 1.3 /1,000 bed days (NHS Average 2.4)

EKHT C difficile by hospital New cases by month and site May 2007



	6M1	6M2	6M3	6M4	6M5	6M6	6M7	6M8	6M9	6M10	6M11	6M12	7M1	7M2	7M3	7M4	May 07
Canterbury	24	12	16	13	16	6	5	8	4	7	12	7	5	4	2	6	4
Margate	24	26	24	15	11	13	11	11	12	6	13	7	4	9	9	6	8
Ashford	15	28	24	16	5	5	18	11	6	12	8	11	11	4	7	5	4
EK-total	63	66	64	44	32	24	34	30	22	25	33	25	20	17	18	17	16

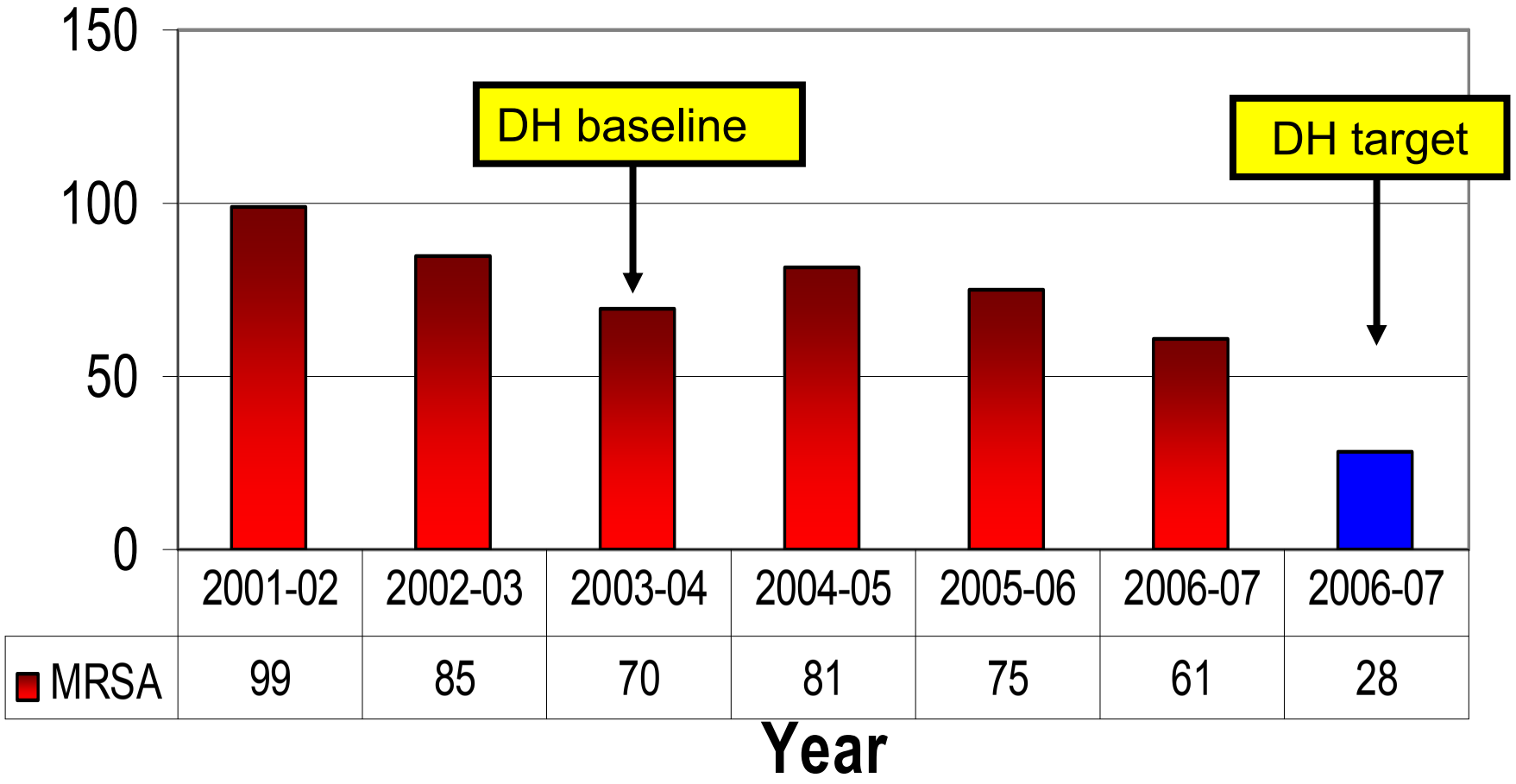
EKHT C difficile rates were below the NHS average during 2006 and have fallen further during 2007



MRSA blood stream infections

- DH target is 60% reduction on figure for 2003-04

EKHT MRSA 2001-02 to 2006-07
Reduction from 99 to 61



South East versus National rates

Ascending rates of MRSA bacteraemias by Trust in England October 2005 to March 2006

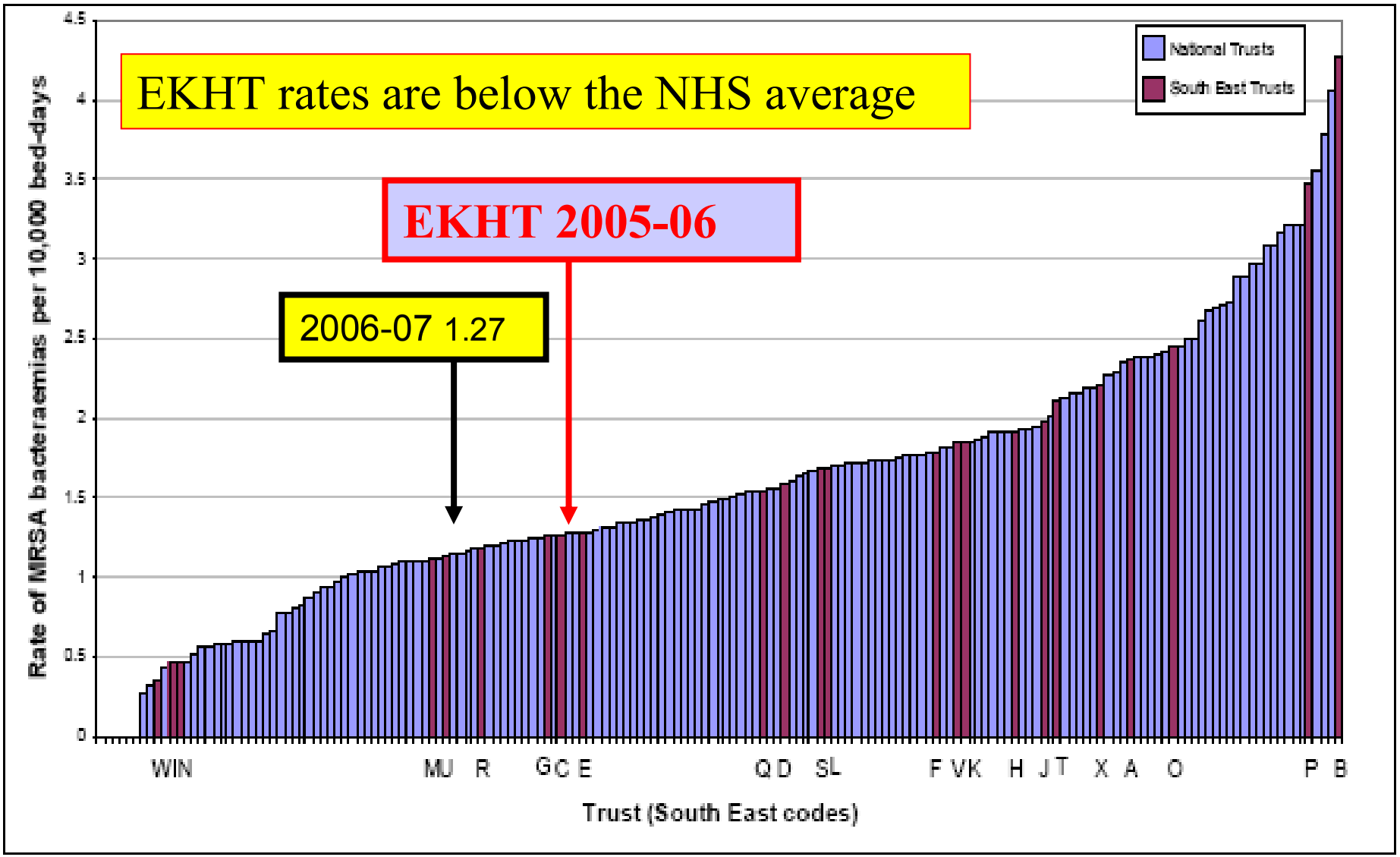


Figure 1: Ascending rates of MRSA bacteraemias per 10,000 bed-days by Trust in England from October 2005 to March 2006. South East NHS Trusts are a different colour and have their respective anonymisation code. Source: HPA MRSA bacteraemia 6-monthly data April 2001 – March 2006.[6]

MRSA EKHT

- MRSA rate is below average and falling
- But needs to fall further ….

MRSA control
lessons from Root Cause Analysis Jan-March

- Improved IV line care required
  - standardised IV line policies to be re-launched
  - improved training of junior hospital doctors
- MRSA screening lapses
  - Screening compliance to be performance managed at ward level
- False +ve results due to contamination
  - Blood culture collection protocols to be revised + improved training for staff

Summary

- Infection control has been restructured
  - "ownership" now at a ward level
  - Clinical infection control leads in place
  - Root Cause Analysis being used to identify why infections occur
- C difficile and MRSA rates below national average and continuing to fall

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The Medway NHS
NHS Trust

Infection Control Update
June 2007

Kath Hughes
Infection Control Matron
Medway NHS Trust

MRSA Target

- The Trust has breached this target for 2006-7 we had 43 bacteraemias -Target was 29
- The target for 2007- 8 is **19**
- There is a comprehensive plan to achieve this for the coming year, as this includes patients admitted with infections this requires close collaboration with the PCT.

Key Actions to Reduce Infections include

- Compliance with hand Hygiene
- Infection Control training for all staff
- Compliance with the MRSA policy, including screening, isolation and treatment.
- Review of the management of all invasive devices and removal of IV,CVP urinary catheters ASAP
- Compliance with Antimicrobial guidelines
- Use of Central and peripheral line insertion packs to maintain asepsis and appropriate skin disinfection.
- Saving Lives High Impact Interventions to be applied to all relevant patients.

The Medway NHS
NHS Trust

Number of MRSA Bacteraemia Infections

2005/06 Trajectory												2005/06
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2	2	3	2	4	4	2	3	5	5	3	3	38

2005/06 Actual Data												2005/06
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
4	3	4	1	0	2	7	2	2	2	2	5	34

2006/07 Trajectory												2006/07
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1	2	2	2	3	3	1	2	4	4	2	2	28

2006/07 Actual Data												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
4	2	4	6	8	4	2	5	2	3	1	2	43

2007/08 Trajectory												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1	1	1	1	1	1	2	2	3	2	2	2	19

2007/08 Actual Data												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2	2											

Root Cause Analysis (RCA)

- Investigation is undertaken for all MRSA bacteramias. This is lead by the clinical team. Lessons learned are then reported.

- The PCT undertake the RCA for those samples taken within 48 hours of admission if there has been no previous admission the past month.

The Medway NHS
NHS Trust

Commissioners

1. **SHA:**
   daryl.robertson@southeastcoast.nhs.uk
   c.c.
   fiona.bower@southeastcoast.nhs.uk
2. **PCT:**
   Medway:
   martin.reiley@medwaypct.nhs.uk
   Eastern Coastal:
   Sally.Allum@ekcpct.nhs.uk

Send RCA form Part A completed

Confirmation of MRSA bacteraemia. Root cause analysis (RCA) to commence within next working day. Infection Control Team to inform the following:

Primary Care

Pre 48 hours Bacteraemia

Send RCA form Part A and patient demographics

1. Medway PCT
   chris.greener@medwaypct.nhs.uk
2. Eastern & Coastal PCT
   sue.baldwin@shepwaypct.nhs.uk

Post 48 hours bacteraemia

Clinical team complete RCA and return findings to ICT in 5 working days

ICT complete Part B of RCA form

Infection Control Team:
- Complete monthly RCA report
- Complete MESS data

PCT undertake community RCA and complete Part B of RCA form within 5 working days

CEO receives and signs off monthly report

Send Report

Clostridium difficile Toxin (CDT) Target

- New target set for CDT.
- Current rate of CDT for mandatory reporting is 1.99 per 1000 bed days.
- New target 1.75 per 1000 bed days
- This mandatory reporting includes people 65 years and over from all samples received in microbiology. Hence this includes GP and Community specimens.

The Medway NHS
NHS Trust

Mandatory Reporting of *Clostridium difficile* Toxin Diarrhoea Cases (Hospital and Community)

Year	2005/06												2005/06
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period	30	23	18	18	15	12	14	22	16	18	23	28	237 (2.20)

Year	2006/07												2006/07
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period	14	15	20	15	15	20	25	17	15	22	14	23	215 (1.99) to date

Year	2007/08 Trajectory												2007/08
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period - Trust	12	10	10	8	8	10	11	11	12	12	11	10	125
A&E and Community	6	6	4	4	4	6	5	5	6	6	5	6	63
Total	18	16	14	12	12	16	16	16	18	18	16	16	Overall Total = 188 (1.75)

Year	2007/08 Actual Figures												2007/08
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period - Trust	10	14											
A&E and Community	6	10											
Total	16	24											Overall Total =

Actual Data 2005/07 | Projected Data 2007/08 | Actual Data 2007/08

Medway NHS Trust rate of 1000 bed days:	January – December 2004	2.29
	January – December 2005	2.33
	January – December 2006	1.92

N.B. This is the same figure as the HPA mandatory reporting all patients 65 years and over, this is all samples sent to Microbiology including all community samples repeat samples on patients are counted again after 28 days. The rate is based upon 1,000 bed days using activity figure of 107,564 for 2004 (as per HPA).

February 2007

CDT Action Plan

- Prudent antimicrobial prescribing
- Updated antimicrobial guidelines /restricted antibiotics
- Excellent hand hygiene Using soap and water for CDT patients NOT Alcohol hand rubs.
- Isolation of all cases in single rooms and adherence to IC precautions
- Treatment of cases with Metronidazole as first line treatment.
- Environmental cleaning and equipment cleaning to a high standard using Chlorine based product

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Item No 7

By: Graham Gibbens, Cabinet Member for Public Health

Peter Gilroy, Chief Executive

To: NHS Overview and Scrutiny Committee 8th June 2007

Subject: PUBLIC HEALTH STRATEGY FOR KENT

Classification: Unrestricted

Summary: The latest draft of the Public Health Strategy for Kent has been issued. It has been circulated to key stakeholders for comment and discussion before being taken to a meeting of the full county council on 24th July.

FOR INFORMATION

1 Introduction:

1.1 The first strategy for public health in Kent has been produced following the permanent appointment of the Joint Director of Public Health between the Eastern Coastal and West Kent Primary Care Trusts and Kent County Council.

2 Report:

2.1 As a first strategy it brings together the elements of public health that are currently being delivered by a variety of organisations across Kent. It will form the basis for discussions about how public health in the county needs to develop further and in particular how public health priorities should be reflected in the next round of strategic plans for both the county council, e.g. LAA2, after 2010, and the NHS.

2.2 The latest draft of this strategy is attached and will have been circulated to key stakeholder partners for comment and consultation prior to formal adoption by PCT boards and the County Council. The consultation timetable is shown as a final appendix to the draft strategy. It is crucial that all KCC directorates, NHS colleagues and district councils are involved in developing the final iteration of this document so that it can taken to the wider public as the foundation of wider public consultation on the various elements of public health and the priorities for action.

3 Conclusion:

3.1 NHS Overview and Scrutiny Committee Members are asked to note the contents of the strategy and are invited to comment upon them.

Meradin Peachey
Director of Public Health
Ext: 4293

Mark Lemon
Policy Manager
Ext: 4853

A Strategy for Public Health in Kent

May 2007 to September 2008

DRAFT 3

17th May 2007

Eastern and Coastal Kent Primary Care Trust NHS

West Kent Primary Care Trust NHS

Kent County Council

Section 1

Executive Summary

Good health is what we all aspire to for ourselves, families, carers, friends and communities. There are many determinants of health ranging from genetic to where you live and your social and economic circumstances.

Compared to England and Wales Kent has reasonably good health. This masks those communities and families that do not enjoy good health.

The Primary care Trusts, Kent County Council and the District Councils are focussing joint action on six important public health outcomes until October 2008. We will consult the public and partners on future outcomes.

The current outcomes are:

1. Reducing health inequalities
2. Improving mental health and well-being of children
3. Fewer people in Kent will suffer heart disease
4. Improved sexual health and reduction in teenage pregnancies
5. More older people able to live at home with chronic disease
6. Reduce the levels of substance misuse and alcohol above recommended levels

There are worrying trends in childhood obesity, mental health and educational achievement in some areas as well as large numbers of children still living in poverty. Action is not simple. There are responsibilities of parents, carers, communities as well as public services in addressing these. *Kent County Council will keep encouraging all schools to reach the healthy school standards to improve nutrition and physical activity amongst children, the district councils will promote a wider range of options for physical activity in schools, local leisure centres and in the private sector, primary care trusts will monitor child obesity levels and support good nutrition in the early years through health visitors and midwives.*

Are young people equipped to be making healthy choices in life? These are some of the issues facing them, trends in teenage pregnancy, binge drinking, rise in sexual health diseases and mental health. *Kent County Council will arrange media campaigns which reflect the lives of young people, and extend youth services to provide advice on sexual health services, the Primary Care Trusts will develop young people sexual health services in accessible places like town centres and nurses will communicate with young people via texting, district councils will support healthy living centres for young people and extend access to computers.*

In the adult population preventable diseases like cancer and coronary heart disease are reducing but not as fast in some communities in Kent. *Primary care Trusts will extend the NHS smoking quitting service to schools, council buildings, and the private sector, Kent County Council will promote stop smoking to its own staff, District councils will run stop smoking services in their own facilities and promote a greater range of physical activity options*.

As the population is living longer there are rising proportions of older people in Kent. This has a big impact on health and social services in particular. The quality and availability of services to support people at home is crucial as well as older people enjoying a quality life. *Kent County Council will drive the introduction of Telehealth so people can b monitored by their GP at home, Primary Care Trusts will continue to develop services in the community and at home to prevent admissions and assist early discharge from hospital*.

This strategy outlines the numerous action plans and targets that the public sector aspires to in improving health and well-being and concludes with six priority outcomes.

Preface

This is the draft strategy for public health in Kent for consultation. It is the demonstration of the local authorities and Primary care trusts in Kent to improving the health of the people living in the county.

It includes many of the initiatives and plans that already exist within both local authorities and the NHS and initiatives that we need to do. It is intended to be the basis for further discussion with stakeholders to ensure it properly reflects the full range of activity they contribute towards public health and priorities they have for the future. We would very much welcome other directorates in KCC, the wider NHS and District Councils to give us their views on what has been included and to highlight any omissions. We will then be able to adapt the strategy to reflect these comments before issuing a final version for more public consumption.

This doesn't yet address adequately the role of the private sector like leisure services in public health nor the potential of culture, like arts, music and theatre to improve public health.

Ultimately this strategy will form the basis for further discussion about the future of public health in Kent and how it should be reflected in our key strategies such as the next Local Area Agreement.

We also want to know how we can make sure that what we do is what people want and need so please do let us know your good ideas.

Contents

1 Introduction

There are very few, if any, things more important to people than their health or that of their families. For local authorities and the NHS improving the health of the population is arguably the most important responsibility they have. Good health is not just the absence of disease, it includes mental and emotional wellbeing and being fit enough to take a full part in society and do the things we want to do.

The big public health issues of the past, mainly to do with infectious diseases such as typhoid and cholera, were tackled by improvements to living conditions; better housing, cleaner water, improved sanitation, cleaner air and open spaces, and were led by local authorities. More recently public health has been seen as predominantly an issue for the NHS and has come to be identified more with health promotion services than other activities that directly affect the environment in which people live. Inequalities in health still exist as a result of poor living conditions, lack of employment, poor education and for minority groups that experience social exclusion because of, for example, race, social class and disability. It is more difficult to make the healthy lifestyle choices that are necessary to improve the health of yourself and your family if you are poor or live in a deprived area. Whilst most people are now living longer and are generally healthier than in the past the difference between the well off and the poorer people in society is increasing. Much remains to be done to ensure that everyone has the same opportunities to live longer and healthier through investing in communities and their people.

The challenges that face us now are different. Many are problems of people's lifestyle rather than their environment. Obesity is not solely a problem for the disadvantaged and a recent survey found that in some areas of the UK relatively affluent districts suffered higher obesity levels than neighbouring poorer areas. We need to help people make the changes in their behaviour that many aspire to achieve to be healthier.

Changing our behaviour is not easy. We may not be sure what to do. Living a healthy lifestyle should be easy but advice and information can sometimes seem confusing and contradictory. Results can take a long time to achieve both as individuals and communities, making it more likely we will give up trying. At a higher level it may typically take 10-20 years before the improvements in health are reflected in official figures.

There are also serious questions about who is responsible for making changes.

- Should we individually make the lifestyle choices we want without interference from the state
- As parents shouldn't we have the right to decide what is best for our families
- Doesn't the government have a responsibility to legislate against behaviour that is dangerous to ourselves or other people

- Should we be informed and educated about harmful activities, or should we be stopped from doing them
- How can we help people lead the healthy lifestyles most of us want without imposing the “nanny state”?

The government, rightly, places great emphasis on individual choices and personal responsibility. In Choosing Health (the public health White Paper published in 2004) the Department of Health laid out its plans for improving the health of the population. Central to this is people making healthier lifestyle choices backed up and supported by good information and advice as well as the services they may need to succeed.

There is also a place for legislation. No-one seriously campaigns any more to repeal the laws against drinking and driving or for wearing seatbelts in cars or crash helmets on motorbikes. These have worked to reduce the number of fatal accidents on the roads and are supported by most of the population. The ban on smoking in public places becomes law in England on July 1st 2007, but it has taken 40 years from the dangers of smoking first becoming known until public opinion generally supports such a restriction.

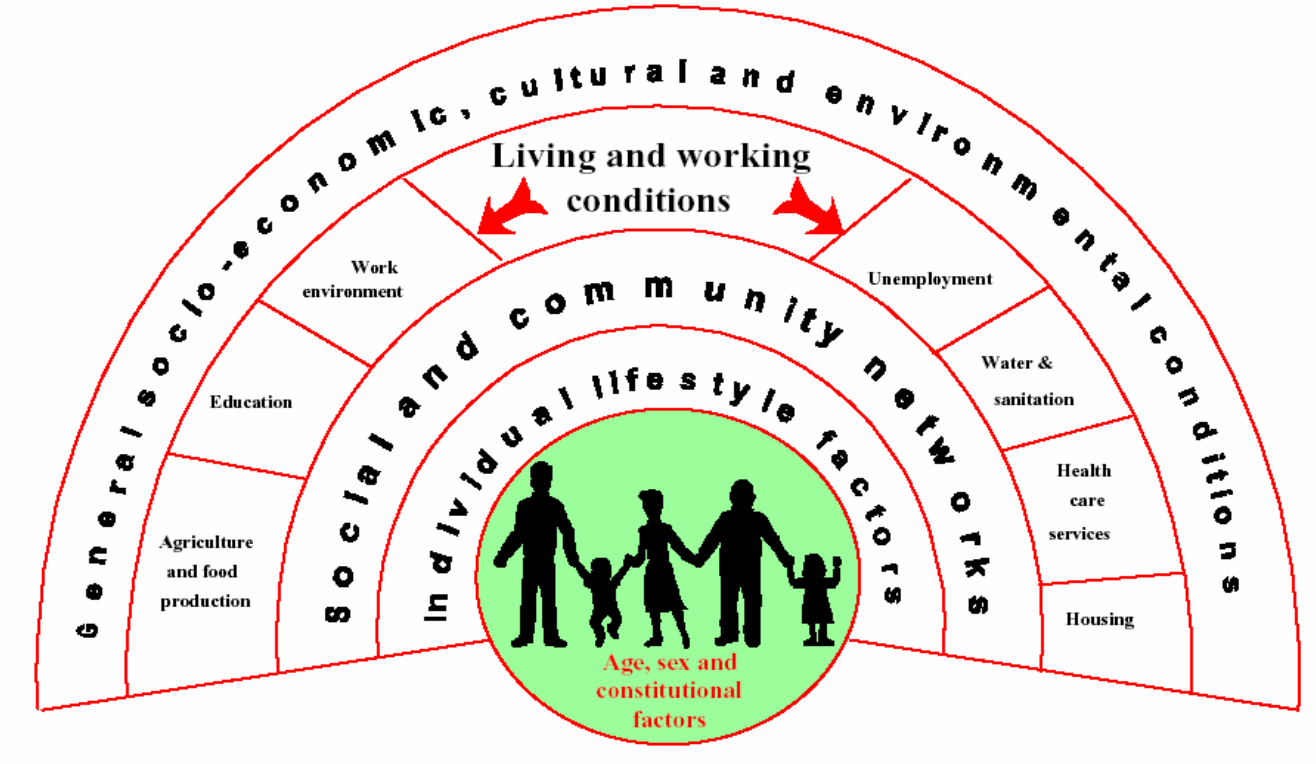
The lesson from both approaches is actually the same. Better public health cannot be imposed on individuals or communities. Unless people agree with what is being done and want to make the changes necessary we will fail. The active participation and engagement of the public is a prerequisite of what we do, not an option. We must work much harder at understanding what individuals, families, carers and communities want, and how they want it done, if we are to make the changes we all want to see. This is not just about information. There can hardly be anyone left that does not know by now that smoking is very bad for your health or that eating fresh fruit and vegetables is very good for you. We need to understand what is stopping people making these choices, even when they want to, and what we have to do to help them.

Public health is complicated. Solutions to public health problems are often complex and always involve a number of people and organisations working together to try and solve them. We need to support people and encourage them without undermining them. Parents and carers need advice and assistance but also must be able to do what’s best for themselves and their families.

We need to work with communities not just do things for them. We must recognise that people generally know best what works for them. Local solutions are the best way to answer local problems but people need the information and advice to make good decisions.

In summary unless the health of the population improves the cost of treating the conditions that come from unhealthy lifestyles will cripple the NHS and other organisations such as local authorities.

There are many things that influence our health. These are often described using the following diagram:



Model of health by Dahlgren and Whitehead

Source: Dahlgren G and Whitehead M "Model of Health"
From Policies and strategies to promote social equity in health, Institute for Future Studies, Stockholm (1991)

How old we are, what sex we are, what genes we have inherited are all important in determining how healthy we will be. Beyond that there are many other things that affect us and that can help us be healthier, or not so healthy, whatever our pre-dispositions may be.

Many of these factors concern the general environment in which we live. How clean is the area? Is our housing decent? Do we have a job? Have we had a good enough education? Do we have the right health care and other services available to us? Many of these issues are mainly the concern of local government rather than the NHS but all need to be tackled through partnerships at every level.

These are some examples of what can be done to affect the wider determinants of health:

- Ensure that all social housing meets the decent housing standard by 2010. As an interim target, action will aim to ensure that between 2003-04 and 2005-06, 400,000 fewer homes rented from social landlords will fall below the decent homes standard. *Delivery mechanism:* East Kent

Joint Planning Board for Housing, local authorities – key role for housing officers

- Ensure that between 2003-04 and 2005-06 80,000 vulnerable households in the private sector will have been helped to make their homes decent. *Delivery mechanism:* local housing authorities – key role for housing officers, housing associations and landlords

- Introduce a housing health and safety rating system to enable local authorities to take action against bad housing conditions the grounds of health and safety, focusing particularly on multiple occupation housing. *Delivery mechanism:* local housing authorities – key role for housing offices

- Tackle some of the causes of ill health associated with living in poorly insulated homes and reduce excess winter deaths. *Delivery mechanism:* East Kent Joint Planning Board for Housing, local housing authorities – key role for housing officers, health professionals, social workers

- Create better and safer local environments, particularly in disadvantaged areas, so that people are more able to engage in social and physical activities in the public spaces close to where they live and work, in pleasant clean surroundings, without fear of crime. *Delivery mechanism:* District councils, Community Safety Partnerships, local authorities – key role for local authority officers, police and community groups

- Improve basic skills and provide improved workforce training and education. *Delivery mechanism:* Learning and Skills Councils with local authorities and prisons – key role for education and skills officers, employers

- Improve employment prospects in the worst areas by tackling employment rates and addressing the issue of inactivity and incapacity. *Delivery mechanism:* JobCentre Plus with local authorities – key role for employment advisors

- Improve the job prospects of black and ethnic minority groups. *Delivery mechanism:* JobCentre Plus with Connexions Services and local authorities – key role for employers, careers and employment advisers

- Develop consistent transport and land use planning policies that improve people's ability to access work and key services and encourage greater exercise. *Delivery mechanism:* local authorities with SEEDA – key role for transport and land use planners, service providers, employers, community groups

- Continue to develop and implement an integrated and sustainable approach to regional economic development which takes into account

the needs of disadvantaged areas and communities. *Delivery mechanism* SEEDA

- Reform Patient Transport Services and Hospital Travel Costs scheme to reflect better the needs of patients. Physical access to health care will have a higher priority in decisions about the location of health care facilities. *Delivery mechanism:* PCT's with local authorities – key role for health and local authority planners

Anything we do will depend upon the involvement and agreement of people and communities. There are a number of ways of talking to people and listening to their views:

- On-line discussion and consultation
- Citizens and residents' panels
- Patient and public involvement forums
- Media campaigns
- Local Authority Members' local boards
- Voluntary organisations
- Public surveys and market research
- Council committees and enquiries
- Parish councils
- Resident's associations

Many organisations that will be partners in delivering better health for people in Kent already have established ways to involve the public and we will make sure these are used to best effect where appropriate.

Social Marketing
Many people want to live longer and healthier lives. They want their children and families to have the best chances in life and to achieve as much as they can. Changing long standing habits and ways if life is very difficult for everyone, but it is changes in behaviour that are most critical for better public health. Everyone needs information so that they can know what they should do to be healthier, but they also need encouragement and support to enable them to actually change how they live. Everyone is different and information and messages that appeal to some people are not helpful to others. What some see as useful ways to control behaviour they would like to change, smoking or eating junk food for example, others see as interference in their lives and freedoms by the "nanny state".

Some people react to strong messages that show the effects of poor lifestyle choices and are affected by media campaigns that shock, whilst others need this information but in order to change what they do must have other messages delivered in ways that they can see are attainable in their daily lives.

Social Marketing is an approach being developed by the Department of Health that builds on the best public sector experience and marries it with commercial and private sector skills in understanding how different people think and what best helps them to change so that they can live the healthier lives that they wish for. Crucially it looks at the priorities people have, how they live their lives and what they themselves think would be the best ways to deliver messages and information that would promote changes in their lives.

Smoking is a classic example. Nearly everyone must know by know that smoking kills people, yet many people still smoke. Some may not know all the details of how it affects them, others (especially younger people) may smoke because it is “cool” or rebellious. Some people may enjoy smoking despite knowing how bad it is for them but will continue nevertheless. Others may have recently given up but be tempted to return to smoking. All of these people, and others, have different reasons for their behaviour and will need different messages and support to help them not to smoke. Social Marketing tries to find out what these different approaches will be by involving people in the design of how information is given, targeting at particular groups of people, and then delivering support and other services in ways that appeal to those who need them.

In Kent we are working closely with the Social Marketing Centre for Excellence to refine these approaches and apply them to our particular priorities. We need to link this to new and creative ways of involving the media in helping people understand how they can live the healthier ways they wish to within their day to day lives.

2 What do we mean by public health?

Public health can mean many different things. In Kent we have some important principles that will define what we do:

Listening to people and communities to find out what makes people healthy
Helping people live longer and lead healthier lifestyles
Preventing ill health
Improving health where people live, work, and play
Creating a healthy and safe environment
Reducing inequalities in health
Protecting people's health with screening programmes
Surveillance of communicable diseases to reduce their impact

This is how we will put into practice the more formal definition of public health that is:

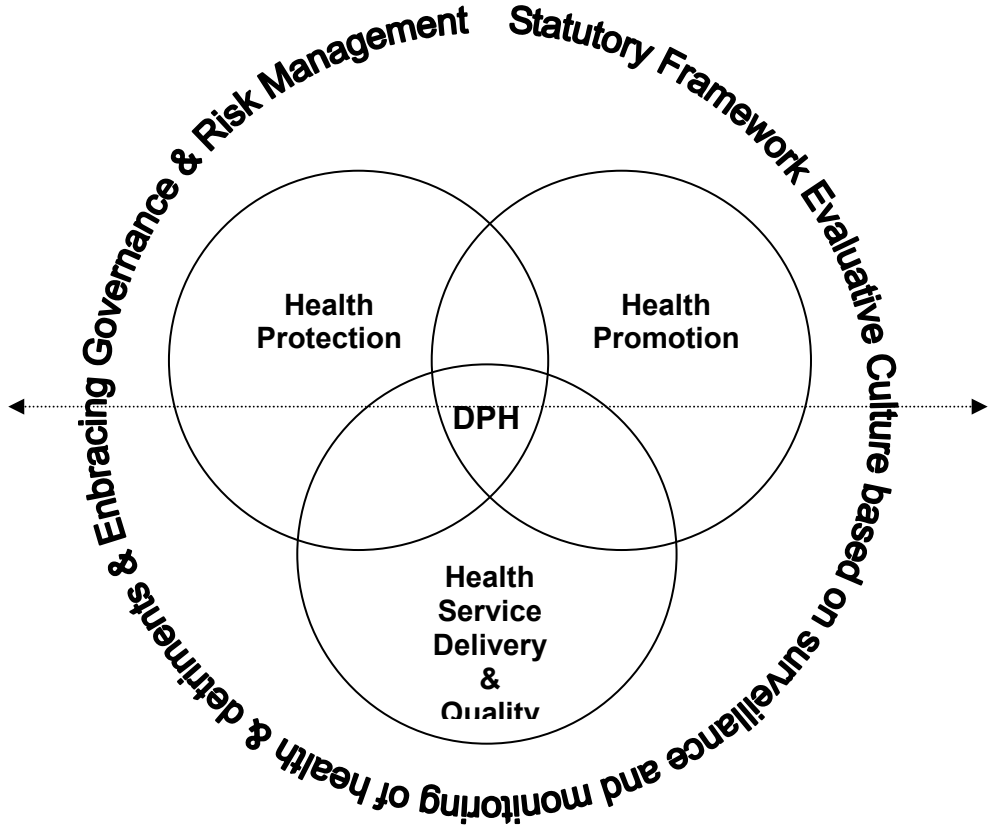
" the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals."

Public health is also often said to focus on three main areas, all of which have a number of associated activities:

Health Protection	**Health and Social Care Quality**	**Health Promotion**
• Clean air, water and food • Infectious diseases • Emergency response • Radiation • Chemicals and poisons • Environmental health hazards • Prevent war and social disorder	• Service planning • Clinical effectiveness • Clinical Governance • Efficiency • Research, audit and evaluation	• Improving health • Reducing Inequalities • Employment • Housing • Family/ community • Education • Lifestyles
Surveillance and monitoring of health and determinants of health supports all three		

This strategy will focus primarily on health promotion because it is in this area that the greatest improvements in health can be made. It is the main way we can make sure that prevention is better than cure.

The three areas all overlap and inform each other:



3 Why tackling health inequalities is so important

Health inequality is the disparity in health status between rich and poor, 'the health gap between the worst off in society and the better off' (Wanless 2001). Moreover health inequality is a concept which covers the whole population and exists 'right across the spectrum of advantage and disadvantage' (CMO England 2001).

Tackling health inequalities requires a commitment to break the link between poverty and ill health and to improve the health of the worst off. It is therefore concerned with the unequal distribution of health manifested in the poor health of the poorest, in differences between socio economic groups, and requires a focus upon the addressing the social conditions which generate these inequalities explained by 'relative deprivation' (Townsend 1979, 1986) and to socio economic inequality.

These are bold statements indicating the national problem. In Kent we recognise the link with poverty but we also recognise many other factors contributing to inequalities.

There are two main measures used for inequality and these are addressed in more detail in section five.

- ***The gap in life expectancy between different areas***
- ***Infant mortality***

In Kent we score well compared to the national average but when you compare districts it is not so good.

Why public health is the business of the whole public sector

Public health has an impact on several important responsibilities of public sector organisations:

- *Civic and community leadership*

Many organisations in the public sector, including local authorities, have a community leadership role that requires them to identify and address the major issues affecting those they represent or that use their services. The health of the public is one of the most serious and obvious issues of concern to everyone and should be a major focus of community leadership.

- *Building sustainable and resilient communities*

All communities need to be able look after themselves and have access to the services and support that they need to do this. The less reliance that communities have on statutory services the more independent they are able to be. Better public health is a very important way to help individuals and communities be more independent.

Continued…

- *Public engagement and accountability*

Public sector organisations have a responsibility to ensure that their actions are held to the account of the public. Public health is a very democratic activity that can only succeed when people are properly engaged at every stage in the process of planning and delivering what is to be done and how. Increased participation by people and communities can improve the general relationship between organisations and the people they are intended to serve.

- *Combating social exclusion*

Many public health problems are especially difficult for people who may be excluded in some way from society or their communities. This may be because of physical segregation (e.g.: prisoners) or because of particular characteristics of individuals or groups of people (e.g. disability, ethnic origin, or social class). Combating social exclusion in order to reduce the effects of inequalities it creates is a major priority of both national and local government as well as other providers of services.

4 How will this happen?

No single organisation can produce the changes that are required. We will need everyone involved in public health (and there are a lot of them) to work together effectively. There is a lot of very good work going on in Kent at the moment but it will benefit from joining together better.

The Kent Department of Public Health will:

- Ensure that the best information is available to those involved in planning and delivering public health so that they are as effective as possible

- Influence and inform policy across the public sector to prioritise public health

- Develop strategies and action plans based on local need and what people want

Public health will work through the existing structures such as Local Area Agreements and Local Strategic Partnerships to link all the different partners together. In particular it needs to connect the County Council the Primary Care Trusts and the District Councils so that important issues have a strategic approach coupled with local delivery.

Strategic Health Needs Assessment

Our Health, Our Care, Our Say and Choosing Health are both government white papers that stress the need for a Joint Strategic Health Needs Assessment for the local population. The assessment is the responsibility of the Director of Adult Social Services, the Director of Public Health, and the Director of Children's Services. It must give details of the general health of the population and make recommendations for action to address the problems that are discovered. The priorities for action must inform the commissioning decisions of both the NHS and the local authority, through a joint commissioning strategy, to the satisfaction of the Director of Public Health. Critically these investment decisions must demonstrate clearly that resources are being moved from acute hospital services to those in primary care and the community. (5% over 10 years).

The Joint Strategic Health Needs Assessment is therefore an extremely important way to influence spending on public health. As the big increases in NHS budgets end the movement of funding form hospitals into the community will be a major source of funding for preventative services and public health. It is vital that this assessment properly reflects all the needs of the population and the jointly agreed priorities between the local authority and the NHS benefit properly from this.

Good information and analysis will be crucial and bringing together data from a variety of sources will be necessary. The role of the new Kent Public Health

Observatory will be important but the process will require overall co-ordination to ensure the right priorities emerge. The production of the Joint Strategic Health Needs Assessment will be a vital part of the new observatory, in partnership with the PCTs, in the coming months.

Kent Public Health Observatory

Better public health also needs to be based on high quality and dependable information. We have to know what problems are most affecting people and what works to solve them. To make sure that the people of Kent benefit from the best information available we will create a new Kent Public Health Observatory to integrate public health information across the NHS, local councils, and others.

This will provide:

- Better information for the NHS and councils to plan and develop services
- Better knowledge of health patterns
- Integrated joint needs assessments of the health of populations and care groups
- Easier access to more information for the public on-line

Section 2

5 Health of People in Kent

People in Kent are generally healthier than the English average but there are parts of Kent that do not enjoy good health:

- Life expectancy is a good indicator of the health of a population. The life expectancy at birth in Kent is 79.7 years (females – 81.7; males – 77.6) and is higher than the national average, but when we compare wards in Kent there is a 14 year gap
- Deaths rates from cancers are lower in Kent in comparison to England. They are continuing to decline and are on course to hit the 2010 Our Healthy Nation target but with smoking rates as high as 32% in Swale lung cancer rates are still unacceptably high
- Death rates from circulatory diseases (coronary heart disease, strokes) are also lower in Kent than in England. The rates have continued to decline in the last decade. Kent is on course to achieve the 2010 Our Healthy Nation target but the higher levels of preventable deaths occur in the more deprived areas
- Although the death rates from smoking related diseases are lower in Kent in comparison to national average, smoking still kills over 2,000 people each year.
- Smoking rates among adults vary between districts from 24% in South West Kent to 32% in Swale. The Kent average is 28%
- The rate of Limiting Long Term Illness in Kent is 16.5%, which is lower than Eng & Wales rate of 17.6%, this is peoples perception of their own health
- Although the reported numbers of people with Diabetes in Kent are lower than England there are at least 49,000 people recorded with Diabetes in Kent, complications can be prevented with the right routine tests and healthy lifestyle
- Levels of chronic disease dementia and arthritis are increasing in line with the increasing percentage of the population over the age of 75 years, these have an impact on the health and social care
- Estimated binge drinking is lower than the England average, but any binge drinking has serious side effects and there is a worrying increase among young people
- An estimated 1 in 5 people are obese, more than the England average
- The rate of reported violent crime is lower that the England average, but the rates of domestic violence in Kent are a particular concern
- Teenage conception rates are lower than the average for England but this is still the worst in Europe

Health Protection

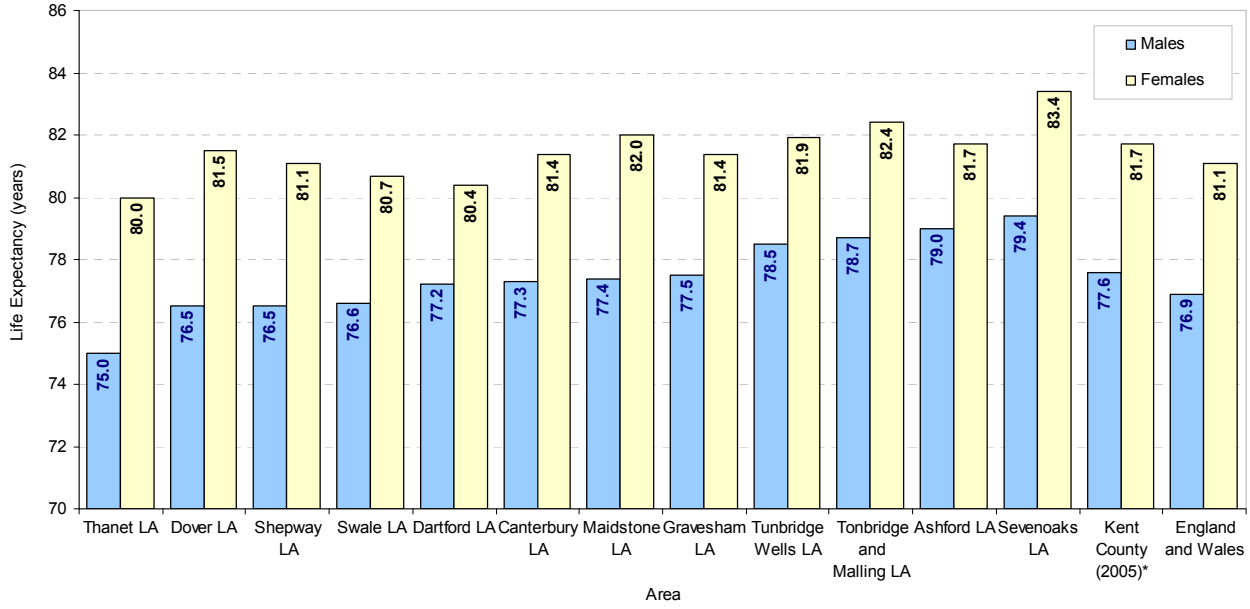
- Chlamydia infection rates are increasing dramatically and this is mostly in young people, this can be prevented with the use of condoms
- Rates of HIV infection is increasing slowly, this can be prevented with the use of condoms

6 Health Inequalities

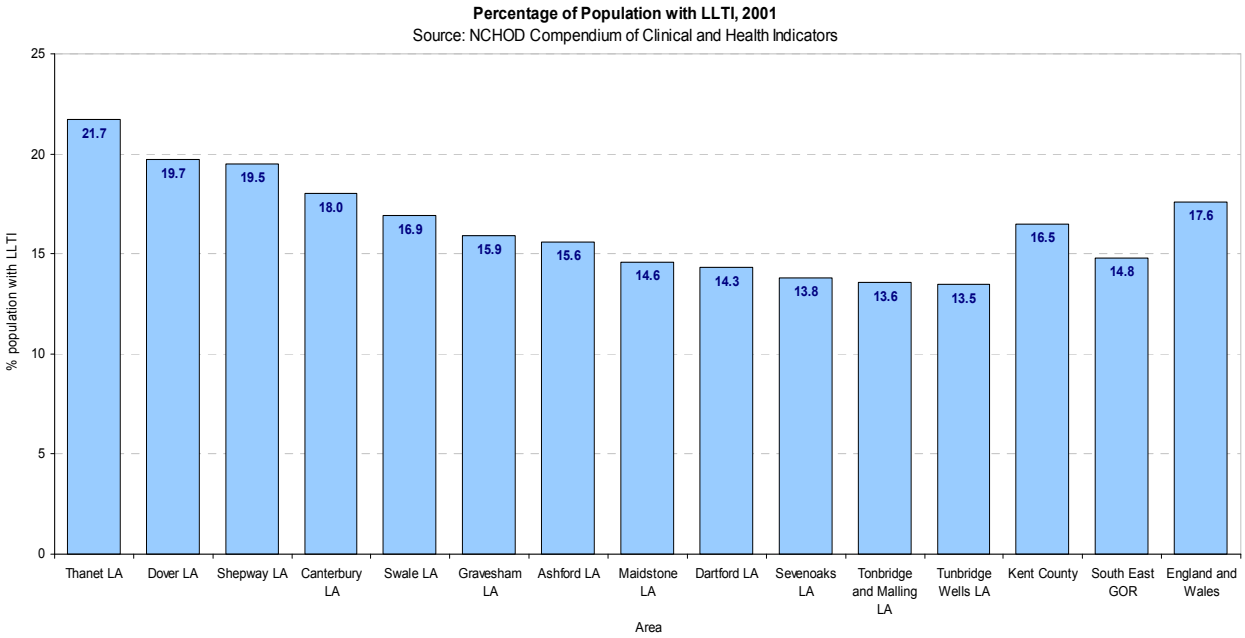
Health inequalities are an important public health issue both nationally and locally in Kent. Health inequalities have been associated with gender, ethnicity, age, socio-economic status and geography. The geographic variation can partly be explained by socio-economic and behavioural factors, but there is evidence to indicate that the place where people live has an impact on their health.

Although the life expectancy in Kent is higher than in England the figure below shows that there is variation between the local authorities. Thanet LA has the lowest life expectancy for both males and females at 75.0 and 80.0 respectively. This is substantially below the Kent County average of 77.6 and 81.7 and the England and Wales averages of 76.9 and 81.1. The district with the highest life expectancy is Sevenoaks with males expected to live to 79.4 and females to 83.4.

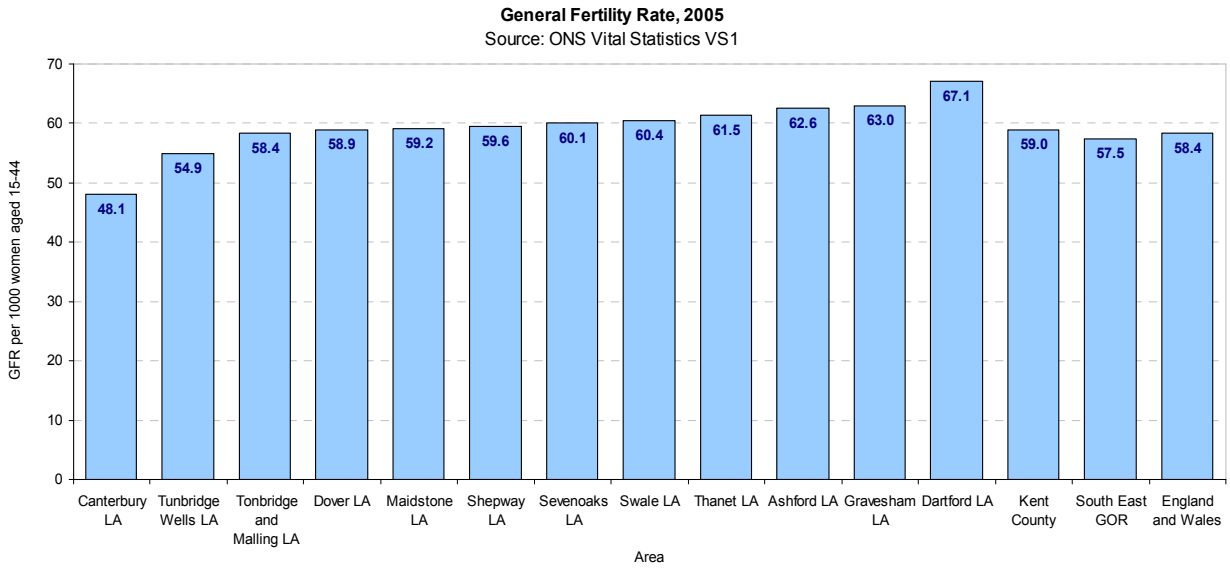
Life Expectancy at Birth 2003-05
Source: NCHOD Compendium of Clinical and Health Indicators



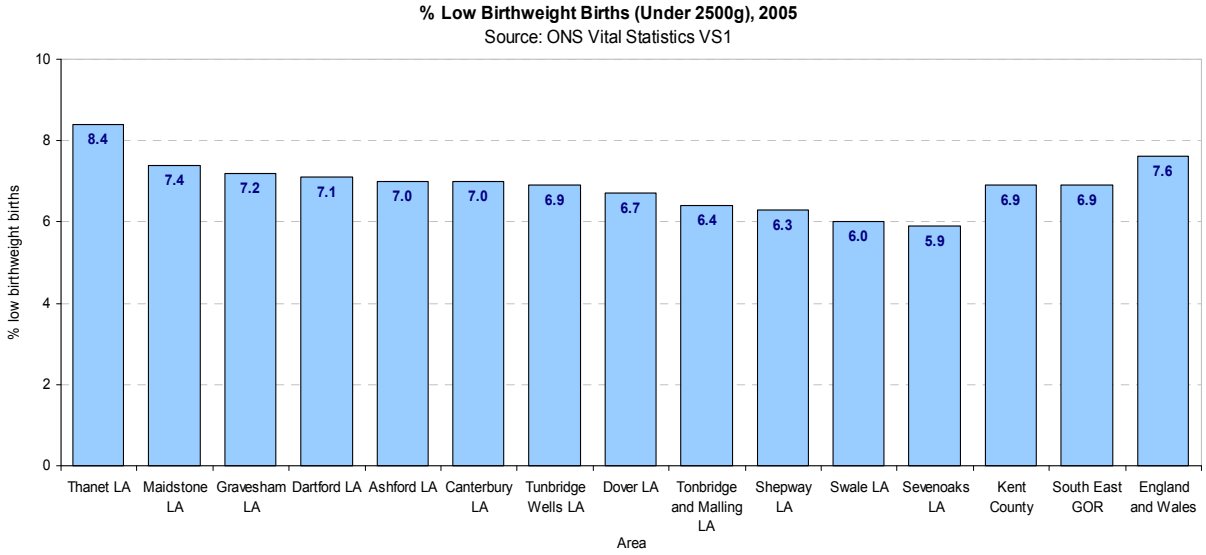
Limiting Long Term Illness (LLTI) in the population was assessed in the 2001 census. This showed that 17.6% of the population reported suffering from LLTI. The rate in Kent was 16.5%. The figure below shows marked variation between LAs in Kent; the highest rate of 21.7% being in Thanet LA and the lowest - 13.5% in Tunbridge Wells LA



General Fertility Rate (GFR) is the number of live births per 1000 women aged 15-44. This impacts on the structure of the population and also its growth; thereby on the health needs of the respective populations. The lowest rate of 48.1% is in Canterbury and next lowest rate occurs in Tunbridge Wells LA - 54.9. Both of these figures are well below the Kent County rate of 59.0, the South East region rate of 57.5 and the England and Wales rate of 58.4. The districts with the highest GFRs are Dartford (67.1), Gravesham (63.0) and Ashford (62.6).



Low birth weight births are associated with health inequalities, with higher rates occurring in areas with higher levels of deprivations. Low birth weight births are correlated with perinatal and infant mortality. It is also considered that they maybe linked to reduced health in later life. The figure below shows the variation in low birth weight births in the different LAs in Kent. The highest rate is in Thanet (8.4%) and the lowest in Sevenoaks (5.9%).



Neonatal and Infant Deaths

Neonatal mortality rate is the number of deaths within 28 days of birth per 1000 live births. It is an indicator of the health status of a population. The Kent rate of 3.2 is lower than Eng& Wales (3.4). There is variation among the LAs, with highest rate being in Shepway LA (6.6)

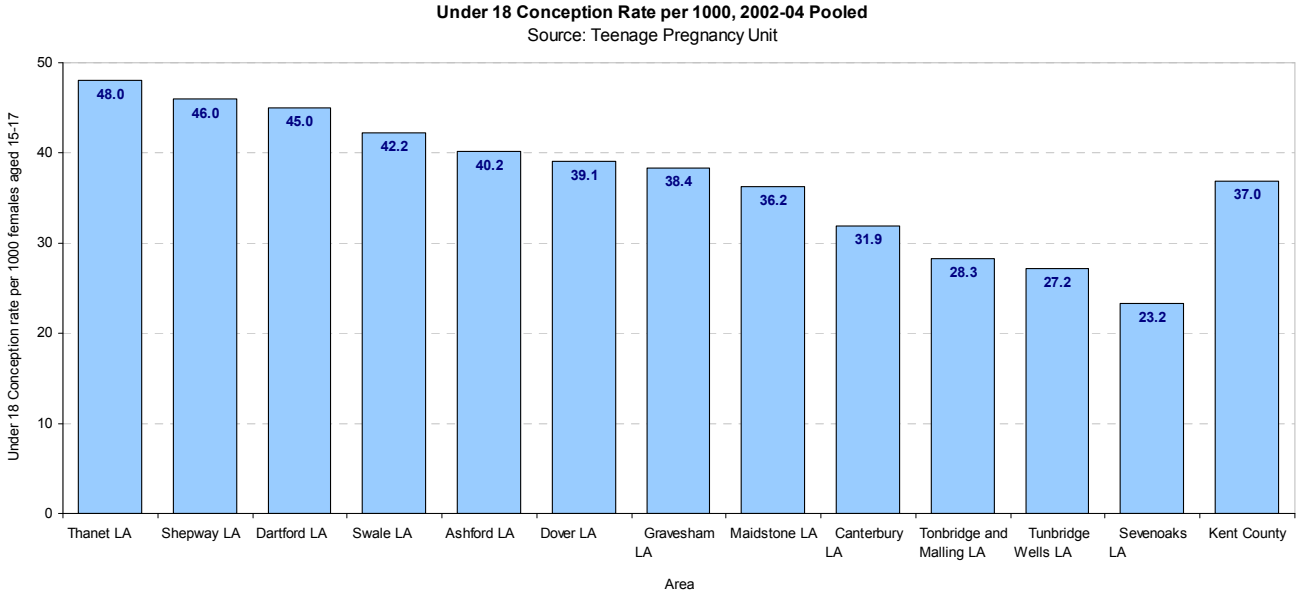
Infant Mortality rate is the number of deaths in the first year of life per 1000 live births. Like neonatal mortality it is an indicator of the health status of a community. As with neonatal mortality the rate is lower in Kent compared to Eng & Wales. Shepway LA has the highest rate in Kent. There is also variation across the LAs in Kent (See Appendix)

It should be recognised that the above rates for the LAs are based on small number of events and therefore likely to show marked fluctuations.

The variation in the neonatal and infant mortality rates for the different LAs shows health inequalities in Kent that need addressing through public health action

Teenage Conception

Teenage conception rate is the number of conceptions that occur per 1000 girls aged 15-17. Not only are there lower health outcomes from these conceptions, they also have a major health impact on the teenagers.
The figure below shows the variation between the LAs. Thanet has the highest under 18 conception rate out of all Kent districts at 48.0 conceptions per 1000 15-17 year old females. Shepway, Dartford, Swale, Ashford, Dover and Gravesham also have higher rates than the Kent County average of 37 conceptions per 1000 females aged 15-17. The lowest teenage conception rate occurs in Sevenoaks LA (23.2). The Kent rate is lower than the rate for England (42.4)



It was earlier shown that there are variations in life expectancy between LAs in Kent. The table below shows that the variations between wards in a LA are even more striking. This demonstrates that public health action to reduce health inequalities in the county will have to focus with communities at different levels

District	**Lowest Life Expectancy**	**Years Life Expectancy**	**Highest Life Expectancy**	**Years Life Expectancy**	**Years Difference**
Ashford	Park Farm South	75.5	Park Farm North	86	10.5
Canterbury	Northgate	76.7	St. Stephens	84.4	7.7
Dartford	Stone	75.9	Castle	85.6	9.7
Dover	St Radigunds	74	River	81.8	7.8
Gravesham	Northfleet North	74.8	Riverview	83.7	8.9
Maidstone	Heath Parkwood =	76.5	Downswood & Otham	85.8	9.3
Sevenoaks	Swanley St Marys	78	Ash	84.3	6.3
Shepway	Folkestone Harvey Central	72.8	Lympne & Stanford	84.9	12.1
Swale	Sheerness East	75.1	West Downs	82.9	7.8
Thanet	Cliftonville West	72.3	Bradstowe	81.9	9.6
Tonbridge and Malling	Snodland East Wrotham =	76.2	Ightham	86.6	10.4
Tunbridge Wells	St James Fittenden/ Sissinghurst	76.9	Brenchley and Horsmonden	83.1	6.2
Lowest and highest wards	***Cliftonville West***	***72.3***	***Ightham***	***86.6***	***14.3***

South East Public Health Observatory (Census 2001)

7 Improving the health and well-being of people in Kent

Reducing inequalities in health

Actions that are known to work	What we will do in Kent
Reduce the number of poorer people who smoke	Smoking cessation programmes run by the PCTs will target the poorer neighbourhoods by working with GP practices to provide counselling groups run stop smoking groups in schools Train counsellors in local authorities to provide groups for clients Train staff in mental health services Work with libraries to access stop smoking services Develop a KCC smoke free action plan and policy
Preventing and managing risks of coronary heart disease, cancer and many chronic illnesses by improving diets and increasing levels of physical activity levels	Increasing opportunities for affordable access to physical activity and sport, like the Charlton football programme Activ mobs programme Conducting a Health and lifestyle survey every 3 years to measure changes in lifestyles Develop a Kent obesity strategy Commission health promoting activity through different voluntary sector and other organisations
Reducing hypertension (high blood pressure) by better primary care and public health action	Monitoring the quality of primary care services for the prevention and detection of hypertension
Improving housing quality by tackling cold and dampness	District council housing strategies in liaison with the NHS Kent affordable warmth programme where district nurses are trained to identify need
Reducing accidents at home and on the road	Targeted work by health visitors to families in need rather than all families Increasing policies for management of speed on the road
To help reduce the differences for some people in how likely their infant children are to die we will:	
Improve the quality and accessibility	Midwives are on the teams in the sure

of antenatal care and early years support for people in disadvantaged areas	start areas and children's centres
Reduce smoking by parents and improve nutrition for children in their early years	Specific stop smoking services for pregnant women Joint breastfeeding policy between Health Visitors and midwives Improve policies and opportunities for women to breastfeed in public places Better monitoring
Reduce the number of teenagers who become pregnant and support teenage parents better	Teenage pregnancy strategy, sexual health services in schools in the wards with highest rates, more 4YP programmes, youth centres providing advice on healthy relationships and contraceptive advice, better access to community GUM services
Improve housing conditions for children who live in disadvantaged areas or circumstances	Housing strategy

8 Children and Young People

Children and young people are a major priority for public health. A good start in life is the best foundation for future health but there are serious challenges emerging. Recent studies have highlighted the danger that the current generation of children will be the first for over 100 years to have a life expectancy at birth shorter than their parents. The reasons for this are unhealthy lifestyles leading to complications such as obesity and its related problems.

The government has recognised this and a key priority in their green paper Every Child Matters is that:

- Children and Young People are physically, mentally, emotionally and sexually healthy, have healthy lifestyles, and choose not to take illegal drugs.

This will be one of the major aims of the new Children's trust for Kent that will bring together all the partners from the NHS, local authorities and the private and voluntary sectors to plan, commission and deliver all services for children.

We need to ensure that all our children in Kent are given a good start to life, supported through their early years when necessary and helped to stay healthy in their childhood. As they enter adolescence we need to enable young people to make safe and healthy choices about their sexual behaviour and their use of drugs and alcohol.

A healthy start

Smoking during pregnancy causes low birth weight babies and other complications for the new born. Alcohol consumption also leads to problems for babies as does misuse of drugs and other substances. The health of the pregnant mother is vital to that of her baby and expectant mothers must have good advice available from midwives and doctors. Smoking is a particular hazard for unborn babies and is most prevalent in women already suffering from disadvantage or living in deprived circumstances which worsens inequalities. There is a national target to reduce the number of women who continue to smoke whilst pregnant:

- We aim to see a 1% reduction per year in the proportion of women continuing to smoke through pregnancy focussing on the most disadvantaged.

When born one of the most effective ways of promoting good health for a baby is through breastfeeding. Breastfeeding is known to reduce infections in children and provides the best natural and healthy nutrition for babies. Current breastfeeding rates are low and we need to do more to encourage mothers to breastfeed their babies. Women from deprived areas are most likely to stop breastfeeding early or not do it at all. Another national target supports this:

- We aim to increase breastfeeding initiation rates by 2% per year focussing on the most disadvantaged groups.

District Councils should also include the availability of breastfeeding facilities in their local guides.

Health visitors are a vital source of advice and encouragement for mothers of new babies and their families. For children with other problems early diagnosis of disability and intervention can help children achieve better in education and life.

Surestart centres in the most deprived neighbourhoods give children under 4 and their families a better start in life with advice and support on parenting problems, healthy eating and cooking skills, early years education and access to therapy and other services often led by parents themselves.

These facilities and services will be expanded across Kent in a wider range of Children's Centres where families can go for help and support on a whole range of issues including healthy eating and taking exercise. The Healthy Start initiative will be part of other moves to encourage better diet and more exercise including growing and cooking fruit and vegetables locally.

Homestart schemes are run by the voluntary sector and offer visitors to give support, advice and assistance to families with children under 5 who need help.

Health for schoolchildren

Schools can have a great influence on children's behaviour but only if they are supported by what happens in the home. Improving the health of school age children must be done in partnership between parents, schools and the wider community.

Healthy Schools is a major programme that aims to ensure that schools help children and young people more chances to achieve their aspirations including employment and careers. There is a great emphasis on healthy lifestyles such as better diet, more exercise and help with issues of sexual health, pregnancy and misuse of drugs and alcohol. Healthy Schools also pay attention to bullying and stress, the buildings children use, the open spaces, catering (including vending machines), food brought into school by pupils, lessons and travel and transport to try and ensure that all aspects of a child's life at school encourage their health and wellbeing.

KCC and its partners have a target that:

- All Kent schools to be engaged in the Healthy Schools initiative by 2009 and promote the benefits of healthy eating, physical activity and sport to children and families.

All school children are now weighed and measured in their reception year and schools, particularly school nurses, will play an invaluable part in reducing obesity in children but other ways of tackling weight problems in children will also need to be found. Affordable access to sports programmes is very important and opportunities presented by major events such as the Tour de France and 2012 Olympics are being developed. Positive Futures is an initiative in partnership with Charlton Athletic football club to appeal to disaffected young people and engage them in sport at a local level.

Positive Futures is a scheme run by Charlton Athletic FC to involve young people, often those experiencing social exclusion, to become involved in sport at a local level. Designed and delivered in the communities it serves, Positive Futures is making a major impact on the lives of disaffected young people and providing new opportunities for many. This is having a positive effect on youth crime, school attendance nutrition and physical activity levels and attitudes to life.

Teenagers

Adolescence is a time when all young people experiment and find out about themselves. We need to make sure that teenagers can explore who they want to be in safety and without causing serious problems in the future. Prime concerns for older children will include sexual behaviour and pregnancy, and education about drugs alcohol and smoking.

Smoking has been targeted in schools in West Kent:

Minimum evidence within the National Healthy Schools criteria requires schools to become 'smoke free sites' and in doing this 'The school is proactive in providing information and support for smokers to quit e.g. promoting access to smoking cessation classes'. The West Kent Young Person's Smoking Cessation and Prevention Initiative was piloted in 6 schools, Hextable School, Northfleet School for Girls, St George's C of E, Thamesview, Axton Chase and Tunbridge Wells Girls School. Since then 11 more schools from South West Kent have received training to implement stop smoking services. The following quotes have been received from three schools involved in the initiative:

" Two groups have now been run for smoking cessation involving 12 students from year 9 and 10" *Northfleet School for Girls*

"The school became a non smoking site in April 2005. Smoking cessation strategies have expanded over time, to include staff support CPD, and 1 hour per fortnight timetabled to support 30 students and 5 staff to begin the process of quitting" *Axton Chase School*

" Drug Education and Drug Incident policies have been developed with support of the Healthy School Specialist and a comprehensive drug education programme is provided. As an outcome the school has moved to smoke free status and has run successful smoking cessation programmes for staff and pupils" *Ifield School*

GUM clinics must become more friendly and welcoming for younger people. The appointment systems should give way to a drop-in service that can be offered in a non-stigmatising place, such as a Gateway.

We must tackle problems of binge drinking by young people and this will be an important part of the KCC committee that will be set up later this year to investigate alcohol use and problems in the county.

Young people are also an important focus of the Kent Drug and Alcohol Action Team who have an objective to help young people resist drug misuse in order top fulfil their potential in society.

In addition KCC is committed to:

- We will develop a hard hitting campaign during 2007 as a way of reaching young people to make them aware of the dangers of alcohol, drugs, smoking and early or unprotected sex.

Teenage pregnancy is a particular concern. Having children too young and without the proper support for parenting can cause serious problems for both the mother and the child.

Teenage Pregnancy

Teenage pregnancy rates in Kent better that England but still the worst in Europe. Sexual health diseases are rising particularly amongst young people.

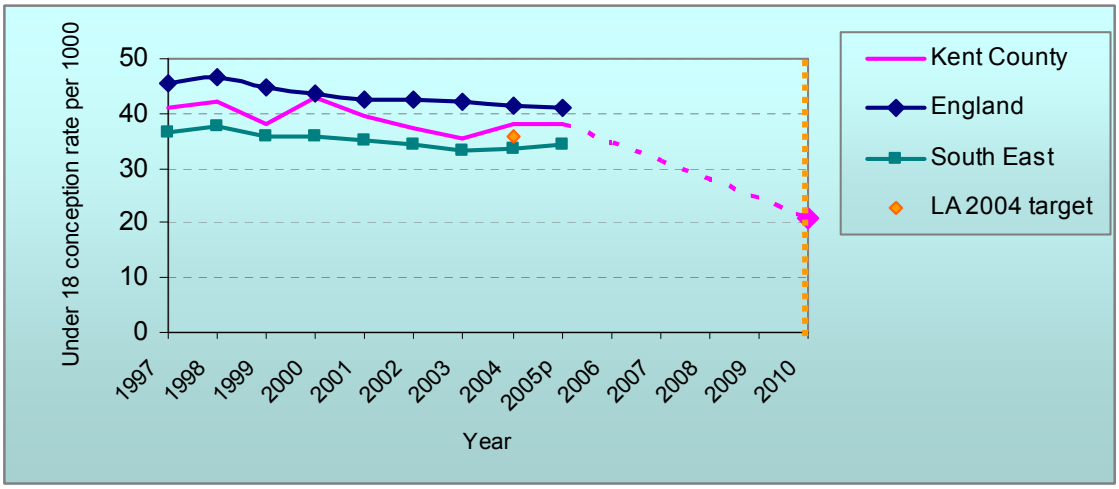
Annual figures were released in February detailing the progress made both at national and county level. (The figures are always 14 months behind because the strategy measures conceptions and not births, the information is provided retrospectively, hence the delay).

Nationally England and Wales continues to see a decrease in the rate, in 2004 the rate was 41.7 and in 2005 it was 41.3 per 1000 females 15-17years.

In the South East the rate unfortunately increased, in 2004 it was 33.5 and in 2005 it was 34.2 per 1000 females 15-17years. Of the 17 counties in the

South East only 7 identified reductions in rate as and the remaining 10 increased, demonstrating the complexities of reducing teenage conceptions.

In Kent the rates decreased, albeit minimally, from 38.1 to 38 per 1000 females 15-17years. This was not the decrease hoped for, it means Kent has had a reduction overall of only 9.7% since inception of the strategy. To be on target to meet the 2010 destination Kent needed to have a 15% reduction by 2004. There is wide variation across the county in strategy progress. Below is detailed the trajectory needed to meet the Kent target.



As well as universal action the Kent strategy has a policy of targeting the 4 high rate old PCT areas of Thanet, Shepway, Swale and Dartford, and pockets of high rates such as in Maidstone.

Under 18s Conceptions By Local Authority District, 1998 - 2004
Numbers and Rates per 1000 females aged 15-17
Source: Teenage Pregnancy Unit

Area	Under 18 Conceptions				% change in rate 1998-2004
	1998		2004		
	Number	Rate per 1000	Number	Rate per 1000	
Ashford LA	87	51.1	93	45.3	**-11.3**
Canterbury LA	98	39.7	87	30.1	**-24.3**
Dartford LA	56	39.3	65	39.5	**0.6**
Dover LA	91	47.1	107	49.7	**5.6**
Gravesham LA	76	43.1	86	44.0	**2.0**
Maidstone LA	81	31.1	99	39.6	**27.3**
Sevenoaks LA	65	31.3	47	22.2	**-29.1**
Shepway LA	104	63.0	82	42.9	**-32.0**
Swale LA	103	45.0	104	41.0	**-9.0**
Thanet LA	132	59.2	120	47.9	**-19.1**
Tonbridge and Malling LA	59	33.1	71	33.5	**1.2**
Tunbridge Wells LA	63	28.7	57	24.7	**-14.0**
Kent County	1,015	42.1	1018	38.1	**-9.4%**

These are the factors that are fundamental to success in reducing teenage conceptions:

- Strong delivery of SRE/PSHE by schools
- Active engagement of all key mainstream partners

- A strong senior champion
- Discrete, credible, highly visible, young people friendly sexual health/contraceptive advice services
- Targeted work with at risk groups of young people, especially Looked after children
- Workforce training on sex and relationship issues within mainstream partner agencies
- A well resourced youth service with a clear remit to tackle big social issues, such as young peoples sexual health

Shepway is an example of how this approach has worked in Kent:

Shepway:

Shepway has had an excellent reduction of 30% since the strategy began. It had the advantage of a high baseline rate when the strategy started and being a small and compact district it is easier to co-ordinate services. There is excellent access to 4YP services, sexual health services have rapidly developed and offer young peoples clinics 6 days a week with Emergency Hormonal Contraception (EHC) available in pharmacies and the local Walk in Centre on a Sunday. The Genito Urinary (Sexual Health) clinics enhance access to condoms and EHC and are located in the Health Centre which is near the town. There has been a full contraceptive clinic in a secondary school and the college since 2003. The area has a full time sexual health/teenage pregnancy outreach worker (ORW) who can supply contraception outside clinical areas. The ORW works with a wide range of organisations and delivers relationship and sex education programmes and also does a lot of 1-1 work with disengaged and excluded groups of young
Continued…
people. The outreach workers are reactive and will work at short notice with any young person referred to them, this works well when a worker observes overt risk taking behaviour and engages the outreach worker to carry out some sessions with the individual or group.

Maidstone has a particular problem with teenage pregnancies in part of the district. They have set up a new partnership that brings a new approach to the problem and will target particular areas in the District.

Kent Children and Young Person Plan

Most of the issues affecting children and young people are covered in the Kent Children and Young Person plan. This plan is based on the priorities of Every Child Matters and forms the basis for action for all organisations in Kent that deal with children. It has a range of priorities:

Healthy schools
Increase school nurses
Support young carers

Staying safe at home and in the community
Making sure children are healthy and happy so that they can achieve at school
Ensure children and young people are engaged in the planning of projects and activities
Put schools at the heart of the community and make sure they support the community
Help children and young people have a safe and decent place to live
Work together to improve the lives and education of looked after children and children with learning difficulties and disabilities.
Help children who are looked after or disabled to have the same opportunities as other children.
(Kent Children and Young People Plan)

9 Local communities leading for health

Local communities are vital to successfully delivering ways to improve people's health. Health Promotion Teams do excellent work to help people change their lifestyles where they live.

The KCC Supporting Independence Programme has been highly successful in reducing the dependency on benefits in a number of the most deprived areas of the county. Helping people to be more independent and have greater control over their lives is one of the best ways of improving their health and wellbeing in the longer term as well as making the community more self-sufficient.

The Supporting Independence Programme is designed to work in 20 of the most deprived wards in Kent. It aims to increase the independence of individuals and communities crucially moving people that wish to, off welfare and benefits into work and training to reduce their dependency on others. SIP has enabled a number of communities to become more self-sufficient and able to deal with their own problems.

There are a number of ways we can work with communities to do this :

- Listening to local communities about what they need to make healthier choices through healthy living centres, community and voluntary organisations, and the new opportunities in the "gateways"
- Develop the use of healthy living centres
- Extend 5 a day initiatives
- Communities for Health programme
- Promoting physical activity including walking and cycling
- Corporate citizenship and procurement strategies

Healthy Living Centres, in Gravesend, Ashford and Maidstone, are facilities within our more deprived communities that offer a wide range of activities as well as advice and support for local people. Often run by the voluntary sector many will have a particular interest in the health and welfare of young children and families. Learning new parenting skills, knowing how to cook nutritious food on a tight budget and the importance of a healthy life for young children are all very important if we are to break the cycle of poverty and disadvantage leading to poor health in later life.

District Councils are crucial to the successful delivery of public health. Many of the conditions that affect people's health (as we have seen earlier) are influenced by the actions of District Councils. Through their Corporate Plans and Community Strategies the District Councils set out their priorities and what they will do to improve the health and wellbeing of their residents. This will cover their key areas of responsibility including:

- housing, including the Decent Homes programme, sheltered housing and regulation of private sector housing standards
- payment of Housing Benefit and Council Tax Benefit
- economic development and regeneration
- development and planning controls
- environmental health and enforcement against nuisance
- provision of facilities for recreation, leisure and sport
- maintenance and promotion of local parks and other open spaces
- transport and concessionary fares

Local action is fundamental to improving the health and well-being of people in Kent and reducing any inequalities in their experience of health. District Councils play a leading role in this work. Every one of the twelve District Councils in Kent has worked with other organisations and the public to see what the local Public Health priorities are. As a result, the Councils have made specific commitments about how they will work with other organisations and the local community to tackle these areas to improve the well-being of their residents. These commitments are set out in each District Council's Community Strategy. District Councils use the Local Strategic Partnership to organise this work and to promote Public Health activities.

It could be said that all of the work of District Councils and their partners contributes to improving health and well-being to some extent, such as Environmental Health and Environmental Nuisances, Housing and Council Tax Benefits, Waste Management and Housing. However, some activity is aimed at more specific Public Health issues. A selection of the Public Health priorities and ways of tackling them are set out below to give a feel for the central role of District Councils and their local partners in improving health and well-being. Some initiatives are being actioned by all Districts, such as introducing smoke free legislation. Many of the District Councils are in the process of updating their Community Strategies in the light of progress already made and new information about the needs of the community and what works best. Specific actions may change as these plans are developed further.

Ashford Borough Council

- Public Health priorities include:
    - Reducing health inequalities
    - Focusing on the health and well-being of children
    - Improving access to primary care service.

- Actions to tackle these issues include:
    - Carrying out an "Equity Audit" to pinpoint where inequalities exist in the area and making plans to redress the balance
    - Carrying out a "race impact assessment" to make sure there is equity for people from minority ethnic communities
    - Planning the number and location of primary health centres for the future, taking account of population growth
    - Neighbourhood Environmental Protection Officers, who will enforce smoking legislation as well as dealing with litter, graffiti and other environmental issues
    - Promoting and providing facilities for leisure and sport, including an exercise physiologist for cardiac rehabilitation and the East Kent Exercise Referral Scheme
    - Working with the most disadvantaged and most vulnerable to provide suitable housing
    - Making best use of parks and open spaces to promote physical activity
    - Ensuring economic development and regeneration, including improving the town centre area and the regeneration of Stanhope
    - Concessionary fares targeted at the elderly to maintain physical mobility and reduce depression
    - Develop "Ashford Voice" to communicate with residents on a range of issues and introduce a consultation charter
    - Implementation of Social Inclusion Strategy, including hard to reach groups.

Canterbury City Council

- Public Health priorities include:
    - Reducing health inequalities
    - Increasing involvement of drug users in treatment programmes
    - Improving access to Community Health Professionals.

- Actions to tackle these issues include:
    - Focusing on pregnant women who smoke
    - Increasing uptake of breastfeeding
    - Reducing poverty and disadvantage by targeting information and signposting to disadvantaged groups.

Dartford Borough Council (in partnership with Gravesham BC)

- Public Health priorities include:
  - Reducing health inequalities
  - Reducing childhood obesity
  - Reducing teenage pregnancy
  - Reducing youth crime.

- Actions to tackle these issues include:
  - Raising health awareness in priority communities and groups
  - The Healthy Living Centre, "The Grand", contributes to reducing inequalities by improving access to sexual health services, smoking cessation services and many other initiatives
  - A wide variety of projects, including cooking, hygiene and healthy eating
  - "Positive Futures" initiative with Charlton Football Club and "don't sit, get fit" programme to increase physical activity amongst school children
  - Developing the "Living Well" project into a Healthy Living Centre.

Dover District Council

- Public Health priorities include:
  - Improving and promoting the range and availability of Health and Social Care facilities
  - Reducing the number of people who smoke
  - Increasing the number of people taking regular exercise
  - Improving access to healthy eating.

- Actions to tackle these issues include:
  - Increasing opportunities to stop smoking
  - Encouraging more people to set up walking bus schemes
  - Launching self-guided walking trails
  - Using the Healthy Living Centre (Project DELTA) to run projects including cooking, hygiene and healthy eating
  - Being a partner in the opening of Fowlmead Country Park providing leisure, recreational and sporting facilities and activities
  - Establishing a Community Sports Network to deliver sports development objectives throughout the District
  - Developing a Skatepark
  - Improving inspection procedure for Health and Safety and continuing food hygiene inspections, including increasing public awareness and enforcement activities
  - Developing, in partnership, Dover Sea Sports Centre and Aylesham Indoor and Outdoor Sports facility.

Gravesham Borough Council (in partnership with Dartford BC)

- Public Health priorities include:
    - Reducing health inequalities
    - Reducing childhood obesity
    - Reducing youth crime
    - Reducing alcohol misuse
    - Increasing physical activity.

- Actions to tackle these issues include:
    - Raising health awareness in priority communities and groups
    - A Healthy Living Centre in Gravesend, which contributes to reducing inequalities by providing information and access to services, including support for young people, specialist services for those referred from education or the Youth Offending Service
    - A wide range of projects including cooking, hygiene and healthy eating
    - Working with children on projects to increase physical activity and reduce childhood obesity
    - Health Action Gravesham Partnership leads many initiatives such as food, nutrition, exercise and working with older people to increase healthy and active lifestyles
    - Ensuring sustainable development in a number of growth and regeneration areas, including Ebbsfleet Valley, Northfleet Embankment, NE Gravesend, Canal Basin and Lord St / Parrock St and Eden Place
    - Ethnic Health and Social Care Forum
    - “Active Listening” Service for young people
    - Helping communities clean up their local environments
    - “Theatre in Schools” drug education and antisocial behaviour in partnership with education
    - “Back to Work” programme in partnership with Jobcentre Plus, focusing on those who find it hardest to get back to work
    - Weekly exercise sessions for older people.

Maidstone Borough Council

- Public Health priorities include:
    - Reducing Health Inequalities
    - Promoting healthy lifestyles to improve Choosing Health priority areas, i.e. to improve mental health and well-being and sexual health and to reduce substance misuse, obesity and smoking
    - Focus on community based services that promote mental health, healthy and independent living
    - Reducing teenage pregnancy
    - Reducing issues related to criminality such as substance misuse, including alcohol and domestic violence.

- Action to tackle these issues includes:

- Developing Community Health Plan for the Borough with a Health Action Team to oversee it
- Teenage pregnancy outreach worker
- Providing information and advice about healthy eating and general health awareness
- Developing lifestyle referral service
- Supporting independence for elderly people
- Park Wood Plus project, which runs a Healthy Living Centre
- Green Gym project
- Community development workers in most deprived areas.

Sevenoaks District Council

- Public Health priorities include:
  - Promoting and improving physical and mental health
  - Improving access to health and social care services.

- Action to tackle these issues include:
  - Increasing participation in healthy lifestyles initiatives and programmes which address the Choosing Health priorities, i.e. to improve mental health and well-being and sexual health and to reduce substance misuse, obesity and smoking
  - Increasing the number of schools participating in the Healthy Schools initiative across the District
  - Improving access to NHS dentists
  - Encouraging use of sports and leisure centres to increase physical activity
  - Targeting priority neighbourhoods and socially excluded groups using health needs assessment / equity audits to inform service planning
  - Putting in place primary care mental health teams offering a range of options.

Shepway District Council

- Public Health priorities include:
  - Focusing on promoting well-being and independence
  - Providing services closer to home or at home
  - Reducing smoking
  - Reducing obesity, especially childhood obesity.

- Action to tackle these issues include:
  - Publication of easy to use literature, both written and electronic, describing services available
  - Smoke free workplace initiatives and piloting exercise and diet programmes in the largest employers
  - Tackling childhood obesity through schools
  - Pilot programme to provide community based services closer to home.

Swale Borough Council

- Public Health priorities include:
  - Reducing health inequalities
  - Preventative strategies for health and social care
  - Improving access to services.

- Action to tackle these issues include:
  - Swale Neighbourhood Renewal Strategy to support improvements in the quality of life and choice in target communities
  - Action to renew areas, such as Queenborough and Sheerness
  - Building more primary care centres and providing more services locally
  - Pathfinder Joint Service Centres linking up activity of public, voluntary and community organisations.

Thanet District Council

- Public Health priorities include:
  - Mental Health and well-being
  - Cancer, heart disease and strokes
  - Older people
  - Children, young people and families
  - Increasing physical activity.

- Action to tackle these issues include:
  - Single point of referral for children with emotional and behavioural difficulties to Child and Adolescent Mental Health Service through a multi-agency team
  - Providing additional smoking cessation interventions
  - Expanding community walking and exercise schemes
  - Healthy eating programmes in schools and the community
  - Falls prevention
  - Developing community based family support services.

Tonbridge and Malling Borough Council

- Public Health priorities include:
  - Reducing inequalities by focusing on vulnerable groups and priority communities
  - Helping people choose healthier lifestyles through exercise, healthy eating and smoking cessation
  - Improving mental health and well-being, sexual health and reducing substance misuse.

- Action to tackle these issues include:
  - Consulting with hard to reach groups

- Extending the Council's lifestyles referral scheme at its sports centres
- Promoting activities and services for young people, including the building of a skatepark
- Continuing regeneration projects in Snodland and East Malling
- Establishing a community project in Trench, North Tonbridge, taking forward the results of a recent health needs assessment
- Helping to promote healthy eating and smoke-free environments
- Working with the voluntary sector to promote healthy living projects.

Tunbridge Wells Borough Council

- Public Health priorities include:
  - Reducing health inequalities
  - Promoting healthy lifestyles to improve mental health and well-being and sexual health and to reduce substance misuse, obesity and smoking.
  - Improving access to services.

- Action to tackle these issues include:
  - Providing information and advice about lifestyle choices, including sexual health, mental health, smoking, obesity and alcohol
  - "Go and try" incentive scheme to increase physical activity
  - Healthy Eating and Smoke free award scheme for workplaces, restaurants and schools

Encouraging social inclusion by encouraging volunteering and including communities, particularly vulnerable groups in decision making including, "Volunteer of the Year" award scheme and the redevelopment of Sherwood Community Centre.

Gateways provide people with a single place where they can go to find out about any of the services or supports they may need in the community. Situated in shopping centres Gateways offer information and advice on a wide range of topics from health and social care to education and employment, volunteering and benefits. Currently operating in Ashford Gateways will soon be appearing in other towns across Kent.

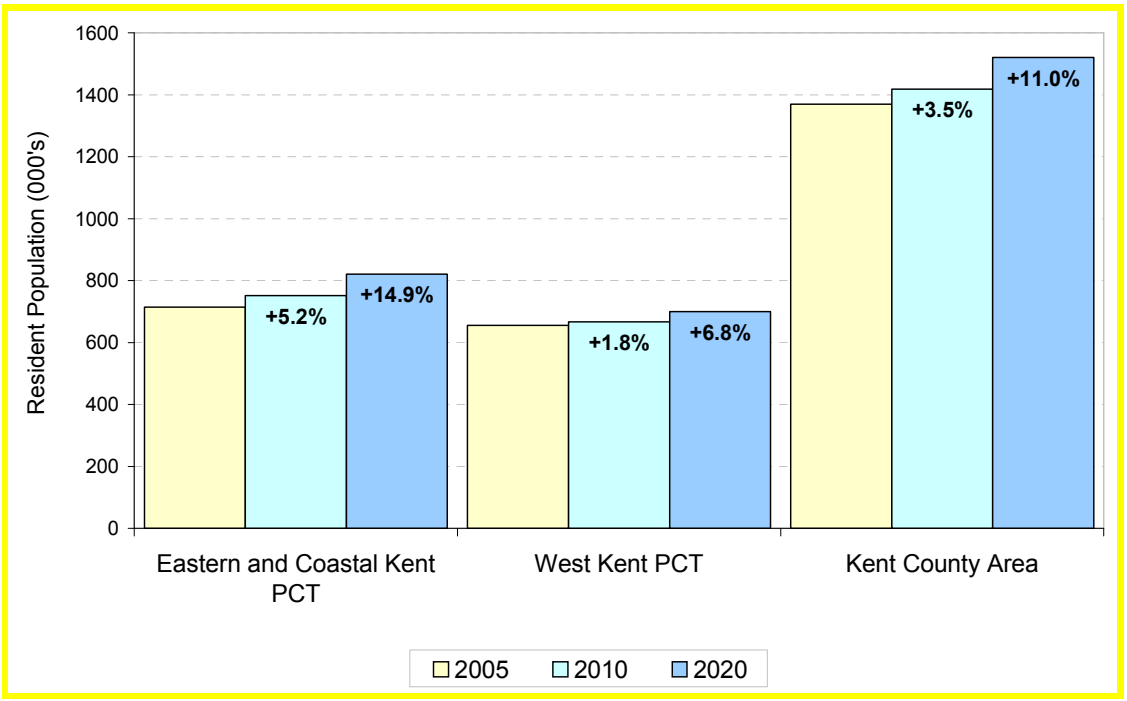
The list reflects the similarities between districts as well as the differences. What we now need to ensure is that action is better co-ordinated and targeted than in the past to make sure that resources are used to best effect and the greatest benefit is felt by people in whatever district they live. Local area Agreements have shown that strategic priorities can be identified and then delivered in ways that are best for each district. We need to do more to make sure that Local Strategic Partnerships are as effective as possible and can make better public health for all a reality.

10 Healthy Lifestyles for Adults

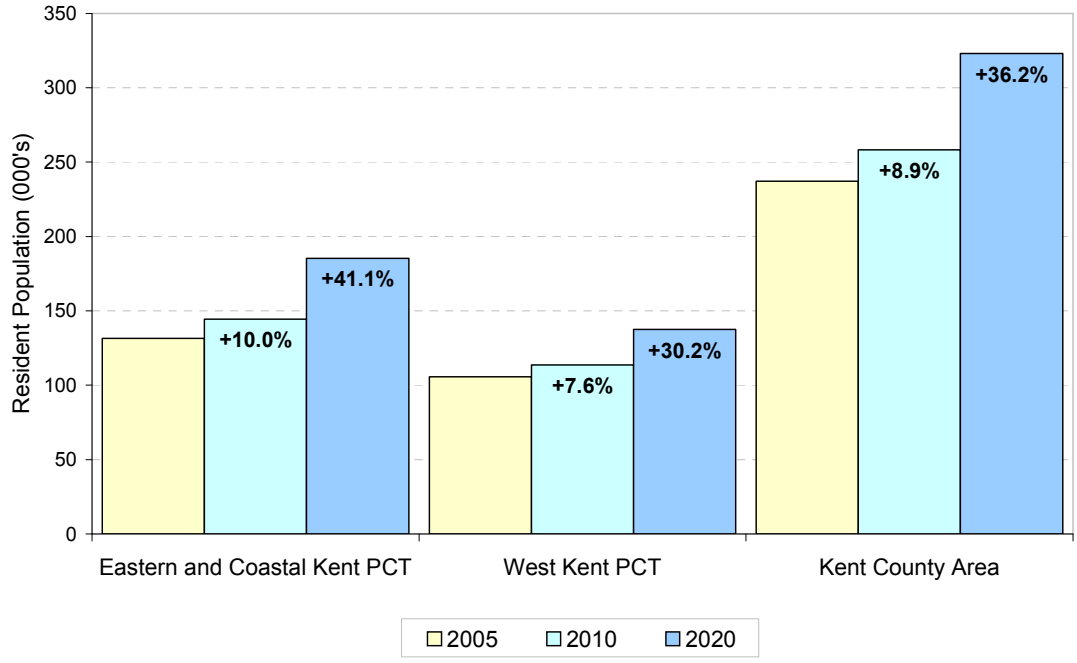
Older people and chronic illness

In recent years the NHS has had great success in tackling killer diseases like coronary heart disease and cancer. Many people are now living longer, which is a very good thing.

Population increase:

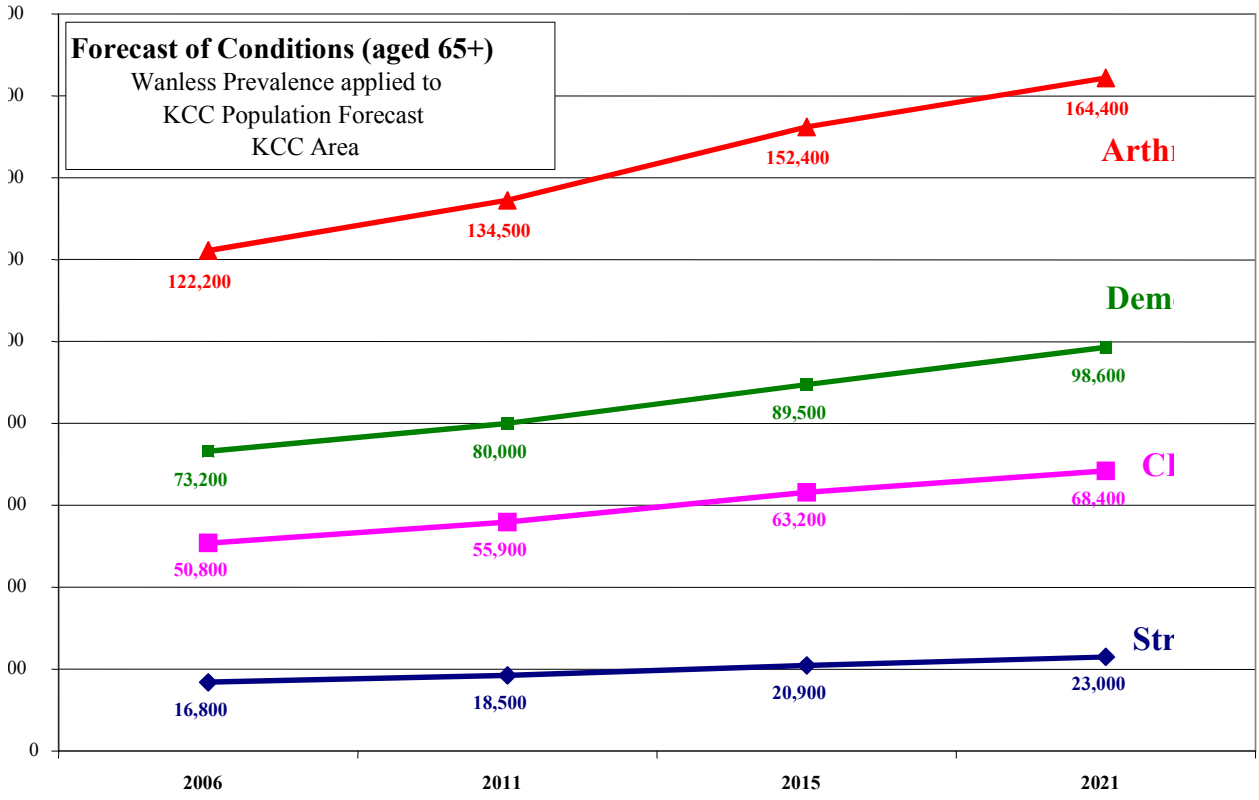


Older person's (aged 65+) population increase:



But longer lives are not always healthy and the number of people suffering from serious illnesses will increase dramatically in the next few years. Conditions such as diabetes, dementia, arthritis, stroke, and chronic obstructive pulmonary disease will all impact severely on health and social care services unless people begin to lead healthier lives before they develop. Improving the health of the adult population is therefore essential if we are to meet the challenge of people living longer.

Forecasts for some of the common debilitating conditions to 2021 show some alarming increases in the number of people that will suffer from them:



At present it is not possible to cure most of these conditions but there is good evidence that all of them can be delayed or alleviated by changes in lifestyles earlier in life. In particular improved diet and taking regular exercise can help to prevent the effects of these conditions and reduce the amount of health and social care people will need to manage them.

The NHS and local authorities all recognise that unless we can help people to improve their general health the services that will be needed will not be able to meet the demand for them. Preventing and managing chronic conditions is now a major priority for public health.

To prevent the onset of chronic conditions and to help alleviate them once they appear there are a number of health issues we need to tackle:

- Smoking is the biggest cause of premature death
- Mental health issues are very important with stress being responsible for a large number of days lost to sickness by people in work
- Obesity leads to coronary heart disease, diabetes, stroke and other serious conditions
- Health in the workplace where many of us spend a large part of our lives
- Alcohol misuse is increasingly serious as a cause of ill-health

Healthy living for the over 50's is a very important priority if we are to stem the tide on people living into old age with serious chronic illnesses that will need a lot of support from health and social care services. Taking exercise is very important for this age group to reduce obesity and to improve their levels of general fitness. Charlton Athletic are working with us to see how we can help middle aged and older people exercise more. Activmobs is another programme developed in partnership with the Design Council to find new ways of enabling people to take exercise that fits around their daily lives and is not about having to go to a gym or other formal facility.

Encouraging adults to improve their lifestyles is essential if we are going to prevent the problems and chronic illnesses caused by obesity and other conditions in later life. We need to:

- Increase levels of physical activity as per LAA target
- Increase participation of problem drug users in drug treatment and the proportion of users sustaining or completing treatment
- Reduce drug related deaths
- Ensure screening of diabetics for early detection of diabetic retinopathy (100% by December 2007)
- Introducing Health trainers will assist individuals develop personal health plans and these will be introduced in Kent during 2007.
- New ways of delivering services such as Community Matrons and intermediate care in the community to prevent admissions to hospital are being expanded.
- Telehealth will be expanded. This is the remote monitoring of vital signs for people with long-term conditions, and will help deliver more care in people's homes.

Telehealth is a major project designed to enable GPs and other health professionals to monitor the vital signs of people with chronic illnesses in their own homes. Using web based technology telehealth means that patients' wellbeing can be monitored by GPs in a surgery whilst the patient remains at home. This saves time and effort for both the patient and the GP (or nurse) and makes much more efficient use of valuable professional time.

Stop Smoking Services and Tobacco Control

Smoking is the main cause of premature and avoidable death in the United Kingdom, responsible for around one in five of all deaths. In Kent, we are committed to not only to providing local services for people who want to give up smoking but also to addressing the wider issues of tobacco control including promoting smoke free public places, tackling underage sales and preventing smoking uptake.

The Tobacco Control Strategy sets out the aims and objectives of KASH to tackle tobacco control issues in Kent. The aims of KASH are:

- to reduce tobacco consumption
- to reduce amount of people that start smoking
- to promote stopping smoking
- to protect against secondhand smoke

These will be achieved by taking a broad approach which involves:

- prevention of smoking uptake through health promotion activities as well as supporting new age of sales legislation
- protection for non-smokers (adults and children) from secondhand smoke by increasing the number of smoke free places thorough smoke free legislation as well as local projects
- help for smokers who want to quit through stop smoking services throughout Kent
- Ensuring that people in Kent are protected from secondhand smoke by making smoke free legislation a success in Kent.
- Working with key stakeholders such as Kent Healthy Schools to prevent smoking uptake through health promotion activities.
- Supporting the new Age of Sales legislation and providing information prior to the launch in October 2007.
- Expanding the alliance to work with a broader range of partners on tobacco control issues.

We will reduce the smoking rate, contributing to the national target rate in manual groups of 26% in 2010

In 2005/2006 Stop Smoking Services in Kent helped 7980 people to stop smoking after four weeks. This was achieved by running specialist group and one to one interventions. The stop smoking services also work closely with GPs and pharmacists to provide a wide network of in-house support. A key

priority to success is ensuring that stop smoking support is available at the most practical places for people accessing help. Specialist support was also available for pregnant women and their families provided in their home and in other convenient locations. Stop smoking support was also available in workplaces, mental health settings, hospitals schools local authorities and prisons.

Local NHS Stop Smoking Services in Kent will continue to help people who want to stop smoking by:

- *Running specialist stop smoking services in local communities across Kent.*
- *Continuing to provide specialist training to the wider health community in Kent.*
- *Providing specialist stop smoking services for pregnant women and their families.*
- *Addressing the gap in smoking rates by targeting areas of high inequality.*
- *Providing stop smoking services in different locations including prisons, hospitals and workplaces.*

- *Exploring new ways to work with and provide services for a wide range of partners.*

Other important locations for promoting services to stop smoking can include libraries, youth centres and schools.

Mental Health

Mental well being has not been given as great a priority as other aspects of public health, yet it frequently underpins and interacts with wider physical and social aspects of health. We need to incorporate the positive promotion of mental health and well being into public health strategies plans and practice.
As there is growing evidence of the links between how mental, physical health and well being interact with each other, further delay in prioritising mental health promotion could be very serious

Poor mental health is a major contributor to ill health and its effects are very costly:

- Mental Health accounts for about a third of GP consultations
- It affects severe disabilities and morbidity and constitutes nearly a quarter of the amount of disease
- It costs the NHS more than £77 billion per year
- Suicide though decreasing, remains a major cause of death in England and Wales
- Stress is the commonest reported cause of sickness absence.

However, the mental health is not served as well as it could be by public health:

- Recent suicide audits reveal that though suicide is falling in England and Wales generally, it is falling slower in the South East.
- Prison suicides have increased and the risk is particularly high for 15-17yr olds

Our current targets for mental health are to:

- Reduce the death rate from suicide by at least 20% by the yr 2010 (NHS PSA target)
- Reduce the number of people with mental ill-health on incapacity benefit.
- Decrease social exclusion and discrimination encountered by individuals and groups
- Choosing Health: making healthy choices easier emphasises importance of improving mental health & mental well-being.

In the future we will:

- Decrease suicide in line with the National Suicide Prevention Strategy, particularly among young people in W. Kent
- Develop an integrated & dynamic approach to well being – a public mental health approach to promoting well being within particular settings supported by local level policy, including LAAs
- Tackle the stigma, shame & negative media images contributing to discrimination

11 Obesity

Rising levels of obesity and its significant impact on health in both adults and children are a national as well as a local problem. Obesity is a complicated issue to tackle and coordinated action is required at all levels. We need to work in partnership with a range of agencies to ensure every opportunity is taken to enable and support our local population to be more active and to eat a more healthy diet.

We should:

- Commission a full range of effective interventions to prevent overweight and obesity supported by a national strategy and working in partnership with local people.
- Improve the care provided to adults and children with obesity, particularly in primary care.

We will develop a comprehensive Kent strategy based on the outcome of the scrutiny committee report. This will include:

- As part of improving local access to opportunities to be active, work is already being undertaken to target specific sectors of the population especially those usually considered as “hard to reach”. Kent is hoping to secure £2 million from the Big Lottery Fund to spring board 13 projects that tackle obesity in the Supporting Independence areas across Kent.

- All future developments in Kent should be required by planning authorities to make provision for healthier lifestyles.

- Local authorities should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, such as walking and cycling.

- Healthy eating is as important as physical activity. There is good local evidence of interventions that have successfully changed attitudes to healthy eating and good practice must be shared and developed across Kent.

- Kent has already consolidated links with the work that is being planned for the 2012 Olympics.

- Across Kent there are good of examples of “exercise referral” by GPs. All Primary Care Trusts should encourage GPs to prescribe exercise to patients where appropriate

- There are many local initiatives that are already being developed in the workplace. Workplaces should provide opportunities for staff to eat a healthy diet and be physically active.

- Children in school reception classes and year 6 will have had their weight monitored from April 2007 as part of the national target to halt the year on year rise in obesity amongst children aged under 11 by 2010.

Obesity Select Committee is a group of KCC council members who looked at the issue of obesity in Kent. Through their investigations they were able to identify a number of recommendations as to how we might all work together to reduce obesity levels in the County. These have formed part of the obesity strategy that is driving the activities being promoted to help people lose weight and avoid complications like diabetes, coronary heart disease and arthritis.

A similar committee will be looking at the issue of alcohol use very shortly.

Physical Activity

Along with healthy eating, physical activity is an essential source of maintaining good health, and taken regularly, is proven to reduce the risk of coronary heart disease, obesity, dementia and some cancers.

Nationally and locally the gap between those who undertake physical activity and those who do not is increasing. People in Kent will be helped to take more exercise by:

- Promoting new ways of exercising including expanding existing opportunities to provide real access to physical activity to meet the needs of the community. Developments should involve communities in the design, planning, delivery and evaluation so that they are appropriate to the needs and lifestyle of local people.

- The Kent Department of Public Health will support partnerships between the County Council (especially Kent Sports Development, Communities, Children, Families and Education and Environment and Regeneration directorates), the NHS and Primary Care Trusts, District Councils, the Voluntary Sector, and the Private Sector to promote physical activity in the public and private sector workforce.

- Applying and mainstreaming Social Marketing and other marketing techniques to new developments to ensure they are what people want.

The range of physical activities and initiatives in Kent contribute to the commitment Kent County Council has to the improved health and wellbeing of Kent's residents. This is being measured through LPSA target 10 to increase levels of physical activity amongst children through education and schools, Sure-starts, Children's Trusts, Sports Development, and Youth Work (and others).

Another part of this target is to increase the number of adults who participate in sport, exercise and active leisure 5 times a week or more for at least 30 minutes to 29.9% by December 2008 (2005 baseline: 24.4%). Walking programmes, GP referrals, health promotion activities, Activmobs and information services such as "What's on in Kent" are examples of new programmes supported by Kent Department of Public Health that will increase opportunities for exercise across the county.

Thanet

- **Community Sporting Network:** a new direction in delivering activity involving the collaboration of key agencies and partners.

- **Funding from Pfizer**: £10,000 This will fund a 'Grow to Grow' project (healthy eating/physical activity/allotment project linked with the community and schools) and to reinstate and evaluate the veg bag scheme.

- **Resolutions/Lets Get Started**: Adapted from the successful Dover project, the mini version will roll out in KCC libraries across East Kent during Jan 2007. It is proposed that Newington and Margate libraries will host the event for the Thanet area. The remaining 8 libraries in the area will have appropriate signposting to the main sites for the project.

- **Kids Club**: Ramsgate Leisure Centre have agreed to host a kids club. This will target children aged 6-11 years who are overweight/obese, and the programme will run along similar lines to the Ashford club. Parents and teachers from Newington Infants and Juniors are very keen for such a club.

- **Schools Physical Activity Policy**: KCC meeting being held today to discuss developing and implementing an 'Active School - Physical Activity Policy' in Thanet schools. This obviously links with Healthy Schools, but will ensure that this links in with our obesity strategy. As a result of this policy, teachers will have additional training and tool kit to drive this forwards. I am hoping that this will improve links into community programmes and clubs for children and families.

12 Sexual health

There are rising levels of sexual transmitted infections particularly amongst young people. Access to contraceptive services and Genito-urinary medicine (GUM) services are important to prevent and treat infections early.

Services must be offered in sensitive ways that do not embarrass and discourage people from using them. In particular GUM clinics should become a drop-in service rather than one offered by appointment.

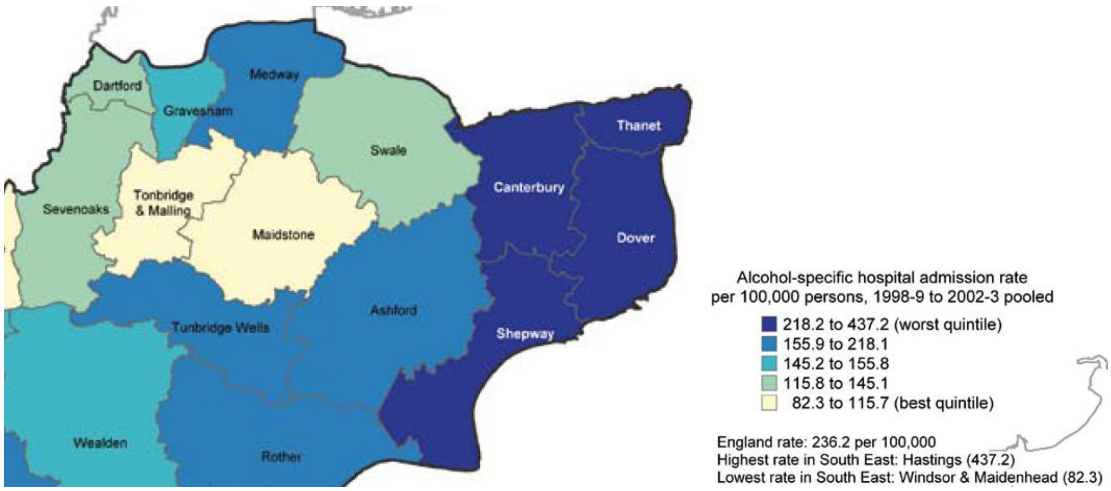
Contraceptive services are provided by General Practices, pharmacists, community services and increasingly there are specific young people services including in schools AND Healthy Living Centres.

Strategies are being developed to increase access to GUM services in the community.

By 2008 there will be 100% access to GUM within 48 hours

13 Alcohol harm reduction

Alcohol in Kent



Alcohol Specific hospital admission rate by local authority.
South East England, 1998-9 to 2002-3.
(Choosing Health in the South East: Alcohol. David Sheehan. SEPHO)

Men and Women in the South East have relatively high consumption rates of alcohol compared to other regions, and the impact of alcohol is wide ranging, impacting on health, crime, anti social behaviour, the workplace and productivity. Young people still drink more than people in other age groups, and occasional drinking is now normal for young teenagers and a quarter of this group are frequent drinkers.

Recent figures show a doubling of alcohol related deaths. East Kent also has the highest levels of alcohol related hospital admissions. The health issue is being seen as serious enough to warrant Kent County Council establishing a Select Committee on alcohol to identify how agencies and partners in Kent can tackle this problem.

A recent report into Alcohol in the South East; *Choosing Health in the South East: Alcohol* (David Sheehan, GOSE and SEPHO) puts forward the following recommendations:

Binge-drinking in young people should be tackled.
Workplace alcohol policies should be implemented.
High risk and vulnerable groups should be targeted.
Additional treatment services should be commissioned.
Public health professionals should work together with local partners to tackle crime and disorder.

Public health are currently engaged in delivering the following to reduce the impact of alcohol on our communities and people's health:

- Investing additional resources in East Kent into treatment for alcohol misuse.
- Leading a project to improve the collection of data on alcohol related violence in A&E's across Kent and Medway. This data will be used to target Police resources to areas
- Produced an Alcohol strategy in East Kent.

There is increasing evidence of the link between youth crime and misuse of alcohol and the rising levels of binge drinking particularly amongst young people. Crime and disorder partnerships are addressing this through various town centre management plans but more needs to be done.

A Select Committee of the NHS Overview and scrutiny Committee of Kent County Council will shortly be convened to investigate alcohol issues. It will report by the end of 2007. Recommendations form this committee report will be used to develop the public health strategy.

Substance Misuse

Substance misuse continues to be an issue in all areas of Kent, in common with other areas across the country. Drug treatment services are commissioned and monitored by the Kent Drug and Alcohol Action Team, a multi-agency team, as part of the National Drugs Strategy. The National Drugs Strategy is being reviewed in 2007.

The Kent DAAT has four priorities:

Young People: To help young people resist drug misuse in order to fulfill their potential in society.

Communities: To protect our communities from drug related anti-social and criminal behaviour.

Treatment: The provision of treatment services to enable people with drug problems to overcome them and live healthy and crime free lives.

Availability: To stifle availability of illegal drugs on our streets via the disruption of drugs marketing and supply chains.

The way in which drug treatment services across West Kent has been reviewed and new service providers are coming into place. Services include:

Community Substance Misuse services in East Kent – KCA
Community Substance Misuse services in West Kent – Turning Point and KCA
Aftercare services in Kent – Turning Point
Alcohol Services in East Kent – East Kent Alcohol Services (Kent and Medway Partnership Trust)
Young Peoples Service – KCA and Kenward Trust

Eastern and Coastal Kent and West Kent PCTs continue to work through the Kent DAAT to identify substance misuse issues and then commission treatment services to meet these issues

14 Work and Health

Work and employment is a major contributor to the promotion of public health both as a means of reducing health inequalities and also because health at work and healthy workplaces are important issues.

Increasing opportunities for work is very important to reduce inequalities. Led by Jobcentre Plus the Kent Agreement has a target to increase the number of people currently on benefit who are helped into work, including clients of social services.

Other measures to be adopted are:

- All Public sector to review healthy workplace policies including health transport policies, stop smoking policies and access to physical activity opportunities.
- Improving working conditions
- Promoting the work environment as a source of better health
- Work with the private sector to enable joint initiatives and share policies
- Smoke free policies in workplaces
- Promotion of cycling and walking

Public Sector employers in Kent have a real opportunity to influence and encourage health and wellness of their employees who are in the main Kent residents. This is a key factor to consider in promoting our public health agenda which actively supports achievement of our targets through workplace programmes & activity. A number of our health priorities have a significant impact on employee attendance e.g. Mental health, physical activity/obesity, smoking, so addressing these factors in the workplace produce a number of beneficial outcomes for both employers and the public health agenda.

Examples of workplace activity includes KCC's Work & Wellbeing initiative that over recent years focused on mental health, (stress management, a case management approach in Occupational Health services, more recently becoming registered as a "Mindful Employer" and providing training events for management on positive management of mental health in the workplace). The 06-08 action plan promotes physical activity and effective weight mgt through a pilot programme covering:
Continued…

- A virtual walking challenge – providing free pedometers to staff
- Promoting and subsidising physical activity sessions during the lunch hour/after work
- Publicising local initiatives e.g. Nordic Walking, group weight mgt sessions

- Providing tips and ideas on nutrition, physical activity, weight mgt via the intranet and posters.
- Trialling a weight & wellness programme and loaning physical activity DVD to staff.

Programmes need to be developed again utilising social marketing, providing different and accessible options to capture and respond to a variety of needs. This can be down through staff focus groups, working with wellness champions who represent staff, mgt, function specialist, using staff surveys, inviting feedback on initiatives and providing a vehicle for offering ideas for example the wellbeing email address within KCC.

Working in partnership to develop initiatives maximises effective use of resources e.g. obesity network meetings to educate, inform & encourage. Utilising the expertise & services of for example NHS leads on walking, smoking cessation and health trainer resource to support workplace activity, opening up internal training programmes to partner organisation to achieve economies in procurement? This strategy encourages partnership working in this regard.

15 Primary care

These are GPs and their primary care teams, Dentists, Opticians, and pharmacists. They are vital to promoting better health not just treating ill health. These are just some of the public health activities in primary care in Kent.

- Wider range of services in General Practice to screen for risk factors, help people monitor and manage their own chronic disease
- In primary care, update practice-based registers to enable patients with CHD and diabetes to receive appropriate advice and care
- Healthy lifestyle, stop smoking and chronic disease advice from pharmacists
- Continue to try and extend the availability of NHS dentists and access to routine monitoring
- Focus on oral health for children and reducing dental caries in under 5 year olds
- Adult social care working with primary care to support people with disability and chronic disease at home
- Exercise on referral schemes
- Reducing variations in referral patterns amongst GPs to ensure patients access the most appropriate professional and that everyone has equal access to services

Pharmacists are a very important par of public health and community health care. Often a first point of call for people who wish to stop smoking they offer nicotine replacement therapy as well as advice and assistance with many other health and lifestyle issues. Lloyds Pharmacy are very interested in having an active presence in Gateways.

16 Health Protection

Protecting the population from the effects of major disasters or outbreaks of infections is a very important part of public health. The Health Protection Agency takes day to day responsibility for monitoring and managing health protection on behalf of the PCTs. They provide a 24 hour on call service to provide expert advice on all issues to do with communicable diseases and potential outbreaks.

Immunisation

- Flu vaccination uptake rates are good at over 70%, this programme is aimed at older people and those with chronic disease
- MMR uptake rates are below 70% in parts of Kent which means that some children are at high risk of these debilitating diseases

Screening

There are a number of new and changed screening programmes and all these will be implemented with quality standards and control as well as ensuring that all communities have access to the programmes. These are the changes that are being introduced:

- *Breast screening uptake rates are 66.3% (2004 – 2006) and is successful in picking up early disease but more women could be screened*
- *Extending breast screening for those women between the ages of 65 and 70*
- *Maintaining high levels of cervical screening over 80% but ensuring that those from ethnic minorities also access the service*
- *Extend retinal screening so that all those people with diabetes can be screened yearly by December 2007*
- *Offer Chlamydia screening to all 16-24yr olds during 2007/08 in community settings*
- *Introduce cystic fibrosis screening during 2007*

Emergency Planning

To ensure that the NHS in Kent is capable of responding to major incidents of any scale in a way that:

- delivers optimum care and assistance to the victims,
- minimises the consequential disruption to healthcare services and
- brings about a speedy return to normal levels of functioning.

it will do this by enhancing its capability to work as part of a multi-agency response across organisational boundaries.

Key target to improve communication at senior level in emergency planning using the Kent Resilience Forum and to ensure that the learning from exercises is incorporated into the plans. Pandemic Flu planning is a priority.

Health Care Acquired Infection

There are unacceptable levels of MRSA and Clostridium Difficile in our local hospitals. This is a national problem not just our local hospitals. We concentrate on our acute hospital but it is important to be rigorous in our community hospitals, community and primary care settings as patients and public move through the different settings.

MRSA

The NHS is committed to halve the MRSA infection rate by March 2008.

MRSA

	2003/04	2006/07	Target 2007/08
Maidstone &Tunbridge Wells	58	41 (up to February)	29
Darent Valley Hospital	24	26 (up to February)	12
East Kent Hospitals Trust			

Clostridium Difficile

This is an emerging problem and reporting is now mandatory. This is a bug that many people carry but can cause serious symptoms in people who are ill, and can be caused by the use of certain antibiotics. It is easy to transmit to other patients in hospital which is why it is a major concern. Good hygiene and hand washing is essential in preventing spread.

The NHS is committed to reducing the rate by 25% in Maidstone and Tunbridge Wells Hospital and East Kent Hospitals and by 15% in Darent Valley Hospital.

To dramatically improve infection control in Kent, Eastern and Coastal Kent and West Kent PCTs are establishing multi agency committees, with advice from the Health Protection Agency, to develop stronger action plans and to ensure these are implemented and that infection control becomes important to each and every member of staff. Infection control policies will also be updated in primary care and community facilities.

In Eastern and Coastal Kent they are aiming for zero tolerance of MRSA and Clostridium. They have established a Local Health Economy wide Health Care Acquired Infection Committee engaging all partners in the LHE, including the independent and care home sector, adult social care, Kent Ambulance Service with a commitment to working together towards Zero tolerance of HCAI. To this end we have established a number of specific task and finish projects including a) the development of common transfer of care standards across the whole health economy, b) the development of cannulation guidelines for the ambulance service and c) a workforce review project linked to implementation of "100% right every time" to handwashing.

West Kent PCT

- is investing in the appointment of an Infection Control Team that will consist of 3 infection control nurses and a lead Infection Control Nurse
- Annual Infection Control environmental audits are undertaken. These include eg cleanliness and handwashing. These will be further developed by the new team
- In addition cleanliness audits are regularly undertaken by hotel services staff.
- Patient Environment Action Team (PEAT) inspections are undertaken annually and the results published http://patientexperience.nhsestates.gov.uk/clean_hospitals/ch_content/peat_2006/introduction.asp
- Alcohol gel is used in clinical areas and signs promoting the use of the gel and handwashing are on display in clinical areas.
- Infection Control training is provided as part of induction training and ongoing training has been provided - by the Health Protection Agency.
- Surveillance data is being collected and reported regularly to the Board.

17 Resources

There are many different sources of funding for the various elements of public health. These may be directly from government departments or through the mainstream activities and budgets of the organisations concerned. Nearly all the activity of the public sector could be seen as influencing health and wellbeing in its widest sense. Similarly much of mainstream NHS expenditure can be seen as improving people's health as well as treating illnesses. However it is probably more helpful to concentrate on those resources devoted more clearly to what most people would see as major contributors to their health. In Kent the main contributions are:

Primary Care Trusts

PCTs have committed specific resources for programmes and initiatives to tackle Choosing Health priority areas, and these programmes are jointly planned with local authorities and communities themselves-this is partnership monies

They are also committed to shifting investment from the acute sector into primary care services and Public Health services and have robust demand management processes in place to enable this shift.

The two PCTs in Kent will receive a total of £4.29m in specific allocations to fund initiatives to deliver Choosing Health priorities. Due to financial pressures not all of this money, in previous years has been spent as intended but the full resource is available for 2007/08.

In addition many initiatives that benefit public health and Choosing Health targets will be funded from the PCT base budgets (like the stop smoking service, community health services, mental health services), local authorities, voluntary organisations, police and others.

Local authorities

Kent County Council has a range of activities that directly contribute to the wider health and wellbeing of the population of Kent. Annual expenditure on social services for adults of c£350m will be used to support many people with long-term conditions. Similarly for Children and Families social services spend c£xxm. All other directorates within KCC also make significant contributions to public health. The Communities directorate is responsible, amongst other things for promoting healthy and sustainable communities as well as libraries and adult education, both key sources of information advice and support, and the Kent Drug and Alcohol Team (see above). The Environment and Regeneration directorate is responsible for promoting the environment within Kent with a specific emphasis on regeneration and addressing deprivation. These are key activities in reducing health inequalities. In addition there is a direct health promotion focus through their stewardship of the County's country parks and open spaces where they promote healthy walks and green gyms amongst other activities to enable people to take more exercise.

District councils

Many district council functions have an impact on the health and wellbeing of their residents. Some are putting additional resources into choosing health. Some of their current priorities are listed above.

Private sector

The private leisure and health industry in Kent is a major employer and provider of health and fitness services and there are some 300 private sector companies operating in Kent.

Voluntary sector

There are hundreds of voluntary organisations in Kent many of them with charitable status and dedicated to improving the welfare of those that can benefit from their activities. Many organisations will be active in supporting, advising and assisting more vulnerable people including elderly people and those with disabilities often, but by no means always, in conjunction with statutory services.

Estimating the resources

Some of this funding is more specifically aimed at Public Health work. Below is an estimate of resources of this kind. However, much more work is needed to identify and be clear about the wide range of resources aimed at developing Public Health.

Core Public Health Teams

The two Kent PCTs and Kent County Council have core Public Health Teams funded by mainstream budgets in these organisations.

Team	**Estimated* Funding £'000**
Eastern and Coastal Kent PCT Public Health Team (includes Health Promotion)	£2,500
West Kent PCT Public Health Team (includes Health Promotion)	£1,300
Kent Public Health Team (two PCTs and KCC)	£300
	£4,100

*These figures are estimates and to be confirmed.

Public Health Programmes
There is a significant number of specific programmes across Kent, funded from a variety of sources, including directly from Government Departments, but also from organisations' main budgets. Work is ongoing to identify such initiatives. Below is a summary of some of these programmes to give an idea of the range of activity and the level of resources.

Programme / Initiative	**Estimated* Funding £'000**
Communities for Health	£ 100
Choosing Health	£ 4,290
Kent Alliance for Smoking and Health	£ 60
Kent Drugs and Alcohol Action Team	£14,546
Kent Teenage Pregnancy Partnership	Tbc
Charlton Athletics Club project	Tbc
Healthy Schools Programme	£120

* These figures are estimates and to be confirmed.

Programmes Contributing to Public Health
There are many programmes running across Kent that make a major contribution to the Public Health agenda. The proportion of funding for each of these projects that could be regarded as specifically for Public Health has not been identified at this stage. The list of projects and initiatives below gives a flavour of such programmes.

- Healthy Living Centres
- Sure Start
- Healthy Schools Programmes

18 Outcomes

This strategy identifies many public health activities and targets and it is important to address them all. However it is important to focus on the six most important public health outcomes as follows.

Outcome 1 – We will see a significant reduction in health inequalities

Short term outcomes	Long term outcomes
▪ Improved lifestyle choices by children in schools in deprived areas	▪ Halt in the rise of childhood obesity ▪ All schools reach the healthy school standard
▪ Improved lifestyle choices by adults and young people in deprived areas	▪ Infant mortality rates in Eastern and Coastal Kent better than England & Wales average
▪	▪ Improved education levels of children in care
▪ Improved access to public sector services	▪ Reduction in the number of people of working age on benefits
▪	▪ Reduction in the number of children living in households with low income in the deprived areas
▪	▪ Reduction in gap in life expectancy from 6.5 years to 6 years
▪ Reduced number of smokers	▪ Reduction in incidence and deaths from cancer

Specific targets that the public sector are already committed to:

Kent Agreement

	Baseline (2004/05)	**Target (2007/08)**
• 4 week smoking quitters who attended NHS smoking cessation clinics	4961	9413
• Mothers smoking during pregnancy	19.73%	17.52%
	04/05	**07/08**
• 5-16 year olds taking 2 hours of high quality sport and PE weekly	45%	87%
• 5-16 year olds taking 3 hours of high quality sport and PE weekly	9%	19%

PCT targets

- 1% reduction per year in proportion of women continuing to smoke through pregnancy (focus on most disadvantaged)

- Reduce smoking rate, contributing to national target rate in manual groups of 26% in 2010
- By April 2008 no-one waits more than 6 months for inpatient admission
- Continue to ensure no-one waits more than 13 weeks for outpatient appointments
- 100% access to a GP within 48 hours

T2010 Targets

- Enter into practical partnerships with the NHS, sharing resources to combat obesity and to encourage people of all ages to take responsibility for their health and wellbeing
- Create and launch initiatives that facilitate more competitive sport in schools, support after-school sports clubs and sponsor more inter-school competitions and holiday sports programmes

Outcome 2 – Improved Mental Health and Well-being for children

Short term outcomes	Long term outcomes
▪ Reduced level; of smoking amongst mothers who are pregnant	▪ Healthier children through mother not smoking
▪ Increased levels of breast feeding	▪ Reduction in youth crime
▪ Children accessing physical activity	▪ Increased educational attainment
▪	▪ Reduction in referrals for tier 4 CAMHS
▪	▪ Reduction in gap in life expectancy from 6.5 years to 6 years

Specific targets that the public sector are already committed to:

Kent Agreement

	Baseline (2004/05)	Target (2007/08)
• Children's centres with full core offer	2	72
• Mothers smoking during pregnancy	19.73%	17.52%
• 5-16 year olds taking 2 hours of high quality sport and PE weekly	45%	87%
• 5-16 year olds taking 3 hours of high quality sport and PE weekly	9%	19%
• Educational attainment at age 16 for children leaving care	55%	65%

- Increased access for children aged 5-15 for tier 2 and 3 child and adolescent mental health services

PCT targets

- 1% reduction per year in proportion of women continuing to smoke through pregnancy (focus on most disadvantaged)
- Reduce smoking rate, contributing to national target rate in manual groups of 26% in 2010
- By April 2008 no-one waits more than 6 months for inpatient admission
- Continue to ensure no-one waits more than 13 weeks for outpatient appointments
- 100% access to a GP within 48 hours

T2010 Targets

- Enter into practical partnerships with the NHS, sharing resources to combat obesity and to encourage people of all ages to take responsibility for their health and wellbeing
- Create and launch initiatives that facilitate more competitive sport in schools, support after-school sports clubs and sponsor more inter-school competitions and holiday sports programmes

Outcome 3 – Fewer people in Kent will suffer heart disease

Short term outcomes

- Reduced number of smokers
- Increased number of adults physical activity levels
- Reduced number of people reporting obesity
- Increased number of adults leading a full active life following a heart attack

Long term outcomes

- Increase in life expectancy

Specific targets that the public sector are already committed to:

Kent Agreement

	O4/05	07/08
• CHD patients with blood pressure 150/90 or lower measured in the last 15 months	79.54%	81.95%
• CHD patients with cholesterol 5mmol/1 or less measured within the last 15 months	66.92%	71.22%
• People aged 15-75 with BMI 30+ as proportion of those with BMY recorded in last 15 months	19.09%	17.75%
• People aged 15-75 with BMI 30+ as proportion of people registered with a GP	18.65%	49.94%
	06	08
• Adults taking 30 minutes sport and physical activity on at least 5 days per week (age standardised rate)	24.2%	28.8%

PCT targets

- Contribute to national reduction in CHD death rates in under 75s

T2010

- Increase opportunities for everyone to take regular physical exercise

- Enter into practical partnerships with the NHS, sharing resources to combat obesity and to encourage people of all ages to take responsibility for their health and wellbeing

Outcome 4 – Improved Sexual health and fewer teenage pregnancies

Short term outcomes

- Increased number of young making confident choices
- reduced number of young people reporting no use of contraception
- Reduced number of new cases of sexual health diseases

Long term outcomes

- Impact on infertility
- Reduced numbers of new cases of HIV
- Teenage pregnancies reduce to the same levels as Europe

Specific targets that the public sector are already committed to:

Kent Agreement

	04/05	07/08
• %age of people contacting sexual health (GUM) services seen within 48 hrs of contact	64.95%	96.82%
• Teenage pregnancy per 1000 females (Reduction in teenage pregnancy rate) 2005	35.5	26.7

PCT targets

- Agreed local teenage conception reduction, also reducing gap between worst wards and the average

T2010

- Introduce a hard-hitting public health campaign targeted at young people to increase their awareness and so reduce the damaging effects of smoking, alcohol, drugs and early or unprotected sex

- Encourage healthy eating by providing nutritious lunches through the "Healthy Schools" programme and launch a range of community-based healthy eating pilots

Outcome 5 – More older people able to live at home with chronic disease

Short term outcomes

- Reduced emergency admissions
- Reduced admissions to hospital and care homes

Long term outcomes

- Better quality life

These are the targets that we are already committed to:

Kent Agreement

	04/05	07/08
• People aged 65 and over helped to live at home	92	95
▪ Reduction in emergency acute bed days aged 75 and over	465677	462908
▪ Reduction in adults in permanent residential/nursing placements	1920	1704
▪ Supporting people clients completing move into independence	1635	5337

PCT targets

- Increase in the number of community matrons
- Achieve target uptake rate for influenza immunisation in over 65s, targeting population with lowest life expectancy

- 80% of people screened for early detection of diabetic retinopathy yearly

T2010

- Increase opportunities for everyone to take regular physical exercise

- Enter into practical partnerships with the NHS, sharing resources to combat obesity and to encourage people of all ages to take responsibility for their health and wellbeing

Outcome 6 – Reduce the levels of substance misuse and alcohol above recommended levels

Short term outcomes

- Increased young people making healthy choices
- Increased numbers of young people accessing drug treatment successfully

Long term outcomes

- Reduced levels of binge drinking among young people
- Reduced crime among young people and adults

These are the targets we are already committed to:

Kent Agreement

PCT targets

- Increase participation of problem drug users in drug treatment and the proportion of users sustaining or completing treatment

- Reduce drug related deaths

T2010

- Introduce a hard-hitting public health campaign targeted at young people to increase their awareness and so reduce the damaging effects of smoking, alcohol, drugs and early or unprotected sex

19 Appendix 1

National Policy framework

Current policy informing public health stems from a number of government initiatives. All of these stress closer working and integration between the NHS and local government with an emphasis on promoting health and preventing dependency upon statutory services. There is an overarching emphasis on addressing health inequalities throughout.

Other key issues are expressed in the Department of Health's PSA with the Treasury including extending life expectancy and decreasing child mortality (+ others), and the annual NHS Operating Framework.

Critically the thrust of all these initiatives is that responsibility for public health extends far wider than the NHS and health promotion services. There is a clear emphasis for interventions to be based on good evidence of need and effectiveness and that people must take responsibility for their health and wellbeing supported by high quality and accessible information and services.

Together these elements constitute the Fully Engaged Scenario required by the Wanless report.

Smoking Kills – DH 1998

Saving Lives – Our Healthier Nation - DH 1999

Securing Our Future Health : Taking a Long-Term View – HMT 2002

Securing Good Health for the Whole Population – HMT & DH 2004

Choosing Health – DH 2004

Creating a patient led NHS – DH 2005

Getting Ahead of the Curve – DH 2003

Our Health, Our Care, Our Say – DH 2006

Neighbourhood Renewal Strategy – HMG 2001

Strong and Prosperous Communities – DC&LG 2006

Every Child Matters – DH 2003

Tackling Health Inequalities – A Programme for Action - DH 2003

Healthy Schools Programme – DH DfES 1999

Joint Commissioning Framework for Health and Wellbeing – DH 2007

Communities for Health Programme – DH 2004

Local Strategies

- The Vision for Kent
- Kent Agreement/Local Area Agreement
- KCC
- Towards 2010
- Corporate performance assessment
- Eastern and Coastal Kent PCT Strategy 2007-2012
    - standards for better health assessment
- West Kent PCT strategy
    - standards for better health assessment
- Community strategies
- South East Coastal Strategic Health Authority Health Strategy
- Kent and Medway Workforce Development Strategy

20 Appendix 2

The Key public health partners

Kent County Council
Primary Care Trusts
Strategic Health Authority
Government Office of the South East
District Councils
Police
Private and voluntary sectors
Health Protection Agency

21 Appendix 3

Life Expectancy at Birth 2003 – 2005
Source: NCHOD Compendium of Clinical and Health Indicators

	Males	Females
Ashford LA	79.0	81.7
Canterbury LA	77.3	81.4
Dartford LA	77.2	80.4
Dover LA	76.5	81.5
Gravesham LA	77.5	81.4
Maidstone LA	77.4	82.0
Sevenoaks LA	79.4	83.4
Shepway LA	76.5	81.1
Swale LA	76.6	80.7
Thanet LA	75.0	80.0
Tonbridge and Malling LA	78.7	82.4
Tunbridge Wells LA	78.5	81.9
Kent County (2005)*	77.6	81.7
England and Wales	76.9	81.1

* Data applies to Year 2005 only

Neonatal and Infant Deaths, 2005
Source: ONS Vital Statistics VS2

	Stillbirth Rate	Perinatal Death Rate	Neonatal Death Rate	Infant Death Rate
	Foetal deaths occurring >24 weeks gestation per 1,000 total births	Stillbirths and deaths <7 days per 1000 total births	Deaths <28 days per 1000 live births	Deaths <1 year per 1000 live b
LA	6.0*	11.3*	6.1*	7.6*
ry LA	3.5*	5.6*	2.1*	3.5*
LA	5.6*	5.6*	2.4*	3.2*
	3.5*	5.2*	1.7*	2.6*
am LA	2.5*	3.3*	0.8*	1.7*
e LA	5.4*	8.4*	4.8*	6.0*
ks LA	1.6*	3.2*	2.4*	4.9*
LA	5.6*	11.2*	6.6*	9.4*
	4.0*	6.7*	3.3*	5.3*
A	4.2*	7.7*	3.5*	4.9*
e and Malling LA	3.1*	6.2*	3.1*	4.7*
e Wells LA	9.6*	10.5*	0.9*	2.7*
nty	4.5	7.1	3.2	4.7
st GOR	4.8	6.9	2.8	3.9
and Wales	5.4	7.9	3.4	5

a rate calculated from less than 20 events.

Limiting Long Term Illness (LLTI), 2001
Source: NCHOD Compendium of Clinical and Health Indicators

	Number of Persons with LLTI	% Population
Ashford LA	15827	15.6
Canterbury LA	23334	18.0
Dartford LA	12087	14.3
Dover LA	20070	19.7
Gravesham LA	15069	15.9
Maidstone LA	19939	14.6
Sevenoaks LA	14943	13.8
Shepway LA	18301	19.5
Swale LA	20329	16.9
Thanet LA	26763	21.7
Tonbridge and Malling LA	14419	13.6
Tunbridge Wells LA	13716	13.5
Kent County	214797	16.5
South East GOR	1157619	14.8
England and Wales	9019242	17.6

Low Birthweight Births, 2005
Source: ONS Vital Statistics VS2

	% Low Birthweight Births
Ashford LA	7.0
Canterbury LA	7.0
Dartford LA	7.1
Dover LA	6.7
Gravesham LA	7.2
Maidstone LA	7.4
Sevenoaks LA	5.9
Shepway LA	6.3
Swale LA	6.0
Thanet LA	8.4
Tonbridge and Malling LA	6.4
Tunbridge Wells LA	6.9
Kent County	6.9
South East GOR	6.9
England and Wales	7.6

Under 18 Conception Rates, 2002 - 2004 Pooled Data
Source: Teenage Pregnancy Unit

Local Authority	Average annual <18 conception rate per 1000 females aged 15-17, 2001/2003
Ashford LA	40.2
Canterbury LA	31.9
Dartford LA	45.0
Dover LA	39.1
Gravesham LA	38.4
Maidstone LA	36.2
Sevenoaks LA	23.2
Shepway LA	46.0
Swale LA	42.2
Thanet LA	48.0
Tonbridge and Malling LA	28.3
Tunbridge Wells LA	27.2
Kent County	37.0

General Fertility Rate, 2005
Source: ONS Vital Statistics VS1

	General Fertility Rate
Ashford LA	62.6
Canterbury LA	48.1
Dartford LA	67.1
Dover LA	58.9
Gravesham LA	63.0
Maidstone LA	59.2
Sevenoaks LA	60.1
Shepway LA	59.6
Swale LA	60.4
Thanet LA	61.5
Tonbridge and Malling LA	58.4
Tunbridge Wells LA	54.9
Kent County	59.0
South East GOR	57.5
England and Wales	58.4

Health outcomes vary for people across the county as seen by the variation in life expectancies, infant mortality and limiting long term illness.

22 Appendix 4

The Current Partnerships

There are a number of partnerships that already exist across Kent that bring many of the key organisations concerned with public health together:

- Kent Partnership and Public Service Board

The Kent Partnership includes all the major public and private sector organisations in Kent and provides an opportunity to co-ordinate the actions of all of them towards issues of mutual concern and interest. The Public Service Board is a sub-group of the partnership consisting of the major public sector organisations. It is responsible for The Kent Agreement (the Local Area Agreement for Kent).

- Local Strategic Partnerships

LSP's are local groups often based on district, or groups of adjacent districts boundaries, led by district councils. They have representation from the most important local organisations including Primary Care Trusts and the County Council. LSPs co-ordinate the actions of their members towards issues of local importance.

- Crime and Disorder Reduction Partnerships

CDRP's are the main meeting point for all the agencies involved in dealing with crime (police, probation service, local authorities, education etc). They produce the crime reduction strategies for the local area.

- Children's Trusts

Children's Trusts are relatively new organisations brought into being to ensure that all aspects of services for children and families are properly co-ordinated and delivered. They include the NHS, education, social services, local councils and others.

- Mental Health Partnership Board

The Mental Health Partnership Board is responsible for the planning, commissioning and delivery of all mental health services across the county. Again it has representatives from the whole range of agencies and organisations involved in mental health issues.

- Kent Drug and Alcohol Team

KDAAT is responsible for the planning and commissioning of all services for drug and alcohol misuse in Kent. It has representation from all the major organisations that are involved in drug abuse prevention and treatment.

- Kent Alliance on Smoking and Health

The Kent Alliance on Smoking and Health (KASH) is a partnership between local authorities and organisations in Kent that have an interest in tobacco control issues, in particular smokefree workplaces and public places. The

partnership is steadily growing and already includes members from various organisations such as:

- Kent and Medway primary care trusts
- Kent County Council
- Kent district councils
- Medway Council
- Kent and Medway Trading Standards
- HM Revenue & Customs

The Kent Team

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23 Consultation Timetable

Kent Public Health Strategy

Timetable for Agreement at Forums across Kent

Organisation	Forum	w/c 16 Apr	w/c 23 Apr	w/c 30 Apr	w/c 7th May	w/c 14th May	w/c 21 May	Contact
Kent County Council	Cabinet			Papers 01/05/07		Meeting 14/05/07		karen.mannering@kent.gov.uk
	Cabinet Briefing	Papers 19/04/07		Meeting 30/04/07				alice.mclean@kent.gov.uk
	Chief Officers				Papers 07/05/07	Meeting 14/05/07		mike.ballard@kent.gov.uk
	Policy Overview Committee	Papers 19/04/07	Meeting 26/04/07					mike.ballard@kent.gov.uk
Eastern & Coastal Kent PCT	Executive Team					Papers 15/05/07	Meeting 22/05/07	sue.cornell@shepway.nhs.uk
	Professional Executive Committee					Papers 18/05/07	Meeting 25/05/07	sue.cornell@shepway.nhs.uk
	Board			Papers 02/05/07		Meeting 16/05/07		sue.cornell@shepway.nhs.uk
West Kent PCT	Executive Team			Papers 01/05/07	Meeting 08/05/07			tricia.bailey@westkentpct.nhs.uk
	Professional Executive Committee		Papers 24/04/07	Meeting 01/05/07				tricia.bailey@westkentpct.nhs.uk
	Board				Papers 10/05/07		Meeting 24/05/07	tricia.bailey@westkentpct.nhs.uk
Kent	NHS Overview & Scrutiny Committee				Papers 11/05/07		Meeting 08/06/07	David.Turner@kent.gov.uk

West Kent NHS
Primary Care Trust

Directorate of Civic Engagement

Fit for the Future

Update for Health Overview & Scrutiny Committee

8 June 2007

Work on Fit for the Future continues, with the health economy across Kent & Medway on track to deliver a formal update for all stakeholders in July. The public document will describe the work that has been going on within and across health economies over the last year, including:

- Outcomes and key messages from the MORI social research and deliberative event
- Outcomes of local consultation with the public and partners
- Outcomes of the demographic and financial modelling that has been carried out to 2015/16 and the assumptions that we've built into our planning
- Why and what we'll be working on under the Fit for the Future banner both across Kent & Medway and within local health economies, including specific initiatives and next steps

The public document will describe an evolutionary process of modernisation and improvement for the local NHS, providing clarity about the areas we will be focusing on over the next year or so.

For West Kent key initiatives will include:

- Urgent Care – we'll be putting in place 'Urgent Care Centres' where primary care staff can provide a service for non-emergency attendances at A&E. We'll also be considering what more can be done in primary care settings (e.g. GP surgeries and high street pharmacies)
- Planned Care – we'll be looking at key areas where people can be diagnosed and treated in community settings closer to home and reviewing our adult community services to support this
- Maidstone & Tunbridge Wells NHS Trust – subject to the response of the Secretary of State we will be working with MTW to implement the outcomes of the recent Surgical & Orthopaedic Consultation
- Community Hospitals – following the recent review we will be re-vitalising all our community hospitals, including re-opening many of the closed beds, establishing the most modern models of care across all the hospitals and applying for capital funds to upgrade Sevenoaks Hospital and X Ray facilities at Edenbridge. We will also consult on the future of the service provided in the Minor Injuries Unit at Edenbridge, the potential to provide renal dialysis at Tonbridge and the refurbishment, re-building or reprovision of the Livingstone Unit in Dartford
- Children's Services – continuing implementation of the Health Visitors' Review and improving services for children and adolescents with mental health needs (CAMHS) in partnership with the Children's Trust
- Mental Health – we'll be redesigning the adult mental health pathway and improving services for older aged adults with dementia

- End of Life Care – we'll be reviewing the care that's available and working to provide more choice for people at the end of their life

Through all of this we will be continuing on-going discussions with the public and other stakeholders, and are in the process of setting up a Patient Advisory Group to work with us on reviewing and re-designing services. Any substantial variations in service will be subject to full and formal Section 7 consultation as deemed appropriate or necessary in discussion with the HOSC.

Across Kent & Medway we will be focusing on a number of high-level specialty areas (for example vascular and stroke services and trauma services). A major clinical event to support this work is scheduled to take place in July when the National Clinical Advisory Team will be coming to Kent to work with our most senior clinicians across the County. Again, outcomes of this work maybe subject to formal consultation.

At the Extraordinary Council meeting on 24th July in the afternoon we will be sharing more detail about Fit for the Future Next Steps and give councillors the opportunity to speak to a range of clinicians and staff about the service improvements we're planning.

I would value the opportunity for a full discussion with the HOSC, perhaps in September once the public document is published, to talk in more detail about what happens next in West Kent.

Julia Ross
Director of Civic Engagement
8 June 2007